Drug-Free Communities

Local Problems Require Local Solutions

Drug-Free Communities Support Program National Evaluation:

2016 National Evaluation End-of-Year Report

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Report Prepared For:

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Drug-Free Communities Support Program

The Drug-Free Communities (DFC) Support Program 2016 National Evaluation End-of-Year Report provides an annual update on DFC national evaluation findings. Together, the findings inform on progress on achieving the primary goals of DFC:

- Establish and strengthen collaboration among communities, public and private non-profit agencies; as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance use among youth.
- Reduce substance use among youth and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse. [1]

First, an overview of the history and background of the program are provided. Next, evaluation findings are presented in three sections: sector membership data, strategy implementation data, and core measure outcome data. The sector membership data identifies ***who*** DFC coalitions have engaged through capacity building activities. Process data on strategies implemented by DFC coalitions provides information regarding ***how*** DFC coalitions work to bring about community change. Finally, the report presents outcome data reflecting ***change*** on DFC core measures associated with youth past 30-day non-use, perception of risk of use, and perception of parent and peer disapproval of use associated with four key substances (alcohol, tobacco, marijuana, and illicit use of prescription drugs).

History and Background

Created through the DFC Act of 1997, the DFC Support Program funds community coalitions to prevent and reduce youth substance use by emphasizing finding local solutions for local problems. DFC coalitions are made up of representatives from twelve sectors (defined in the DFC Sector Membership section) that organize as community-based coalitions to meet the local prevention needs of the youth and families of their community.

The DFC Support Program is funded and directed by the Office of National Drug Control Policy (ONDCP). ONDCP has engaged several partners to collaborate in supporting DFC coalitions to help them succeed (see Figure 1). The Substance Abuse and Mental Health Services Administration (SAMHSA) provides day-to-day grant award management and monitoring support. Training and technical assistance intended to strengthen capacity of the DFC coalitions, including the required National Coalition Academy, is provided by the Community Anti-Drug Coalitions of America (CADCA). The DFC National Evaluation Team provides technical assistance support to DFC coalitions regarding data collection and reporting. DFC grant award recipients receive up to $125,000 per year for up to five years

[1] Office of National Drug Control Policy (2016). *Drug-Free Communities Support Program.* Retrieved on 7/8/16 from https://www.whitehouse.gov/ondcp/drug-free-communities-support-program

per award, with a maximum of 10 years of grant award funding.[2] Since 1998, the DFC Support Program has awarded DFC grants to community-based coalitions that represent all 50 states, several territories, and rural, urban, suburban, and tribal communities. In fiscal year (FY) 2015, 675 community coalitions were awarded DFC grants.[3] Of these, 376 (56%) were in Year 1 to Year 5 of receiving a DFC Grant.

Figure 1. Drug-Free Communities Support Program: Partners for Change

Notes: DFC Grant Award Recipients are supported in achieving their goals by ONDCP, SAMHSA, CADCA, and the DFC National Evaluation Team. DFC Coalitions engage twelve sectors to achieve change in the community, represented here by the twelve sector icons in the outer circle.

Data in 2016 End-of-Year Evaluation Report

In 2015, ONDCP led the development of a new comprehensive online grant oversight system called DFC Management and Evaluation (DFC *Me*), into which DFC coalitions would submit required reports. This report includes all FY 2015 DFC grant award recipients that submitted a progress report through the DFC *Me* system in August 2016. DFC coalitions reporting focused on the time period from February 1, 2016 to July 31, 2016. Table 1 outlines the number of FY 2015 grant award recipients by year of award. In total, 655 of the FY 2015 DFC coalitions submitted a report in August 2016.[4] In addition, the special section on addressing opioids (see also Appendices B and C) includes preliminary findings and quotes from nine site visits conducted from January to June 2017.[5]

[2] DFC coalitions must demonstrate that they have matching funds from non-federal sources relative to the amount of federal dollars requested. In years 1-6, a 100% match is required. In years 7 and 8 this increases to a 125% match and finally in Years 9 and 10 a 150% match. See the most recent funding opportunity announcement for further information on matching https://www.samhsa.gov/sites/default/files/grants/pdf/sp-17-001.pdf.

[3] In FY 2015, ONDCP awarded 188 new DFC grants and 487 continuation grants for coalitions already in a five-year cycle. In addition, 20 new DFC Mentoring grants, and 3 continuation DFC Mentoring grants were awarded in FY 2015.

[4] This represents 97% of FY 2015 DFC grant award recipients. Additional DFC coalitions may have completed the progress report after the point at which data were received by the DFC National Evaluation team for this report. The DFC National Evaluation team received progress report data after providing SAMHSA project officers with six weeks to approve the progress reports. SAMHSA project officers were likely engaged in ongoing interaction with the 3% of DFC coalitions who did not meet the reporting requirement.

[5] Sites visited in 2017 were selected based on having included information about addressing opioids in August 2016 Progress Reports. During site visits, interviews and focus groups with key staff and coalition members were conducted.

Table 1. Number of FY 2015 DFC Grant Award Recipients Submitting August 2016 Progress Report by Year of Award

Year of Award	Number of Grant Award Recipients Submitting Report
FY 2015 Grant Award Recipients	
Year 1	106
Year 2	94
Year 3	86
Year 4	35
Year 5	43
Year 6	76
Year 7	96
Year 8	58
Year 9	24
Year 10	37
Total	655

Sources: DFC National Evaluation progress reporting guidance, DFC *Me* Reporting System, August 2016 Progress Report

Progress Report Data

DFC coalitions collect and submit a broad range of data biannually. In addition to the sector membership, strategy implementation, and core measures data focused on here, progress report data includes information regarding the community context, focus of coalition efforts (grade levels, key substances), budget, capacity building activities, key challenges and protective assets found in the community, assessment activities, planning activities, and general challenges. DFC coalitions also provide the zip codes that define the community in which they target activities.

Core Measures Data

DFC coalitions are required to collect and submit new core measures data every two years.[6] DFC coalitions may attach new core measures data to either their February or August report once data collection is complete. This report will focus on findings on the current DFC core measures, which were revised in January 2012.[7] Briefly, the core measures are defined as follows (see Appendix A for specific wording of each of the core measure items):

- **Past 30-Day Prevalence of Use/Non-Use**: The percentage of survey respondents who reported using alcohol, tobacco, marijuana, or (illicit use of) prescription drugs at least once in the past 30 days (prevalence of use). Given that the focus of DFC is on prevention, past 30-day prevalence

[6] DFC coalitions are encouraged to collect data from youth in at least three grade levels, with at least one grade level in middle school (Grades 6 to 8) and at least one in high school (Grade 9 to 12).

[7] A few core measures were revised in 2012 while new core measures (i.e., perception of peer disapproval and illicit use of prescription drugs) were also added. For unchanged core measures, data has been collected since 2002.

data are reported here as prevalence of non-use. That is, the data reflect the percentage of youth who did not report use of the substance in the prior 30 days.[8]

- **Perception of Risk**: The percentage of survey respondents who perceived that use of a given substance has moderate risk or great risk. Perceived risk of alcohol use is associated with five or more drinks of an alcoholic beverage (beer, wine, liquor) once or twice a week (binge drinking of alcohol). Perceived risk of tobacco use is associated with smoking one or more packs of cigarettes a day. Perceived risk of marijuana use is associated with using marijuana once or twice a week. The perception of risk of prescription drug use core measure is associated with any use of prescription drugs not prescribed to the user (illicit use).
- **Perception of Parental Disapproval**: The percentage of survey respondents who perceive their parents would feel that regular use of alcohol (1-2 drinks nearly every day) or engaging in *any* use of tobacco, marijuana, or illicit prescription drug use is wrong or very wrong.
- **Perception of Peer Disapproval**: The percentage of survey respondents who perceived that their friends would feel it would be wrong or very wrong for them to drink alcohol regularly (1-2 drinks nearly every day), or to engage in any tobacco, marijuana, or illicit prescription drug use.

DFC Reach

In FY 2015, ONDCP awarded 188 new DFC grants (i.e., 108 Year 1 and 80 Year 6) and 487 DFC continuation grants, bringing the total number of DFC grant award recipients included in the evaluation to 675 (see Figure 2).[9] DFC coalitions identify their catchment areas by zip code. Each DFC coalition indicates all zip codes in which their grant activities are targeted, and these zip codes were merged with 2010 U.S. Census data to provide an estimate of the number of people that DFC grantees may reach and impact.[10] The total population of all catchment areas of DFC grantees funded in FY 2015 was approximately 61.7 million, or 19.7% of the population of the United States. These catchment areas include approximately 2.5 million middle school students between the ages of 12-14

DFC Potential Reach: 1-in-5 Americans lived in a community with a DFC funded coalition in 2016

The 675 DFC coalitions funded in FY 2015 target communities with 61.7 million people, 20% of the population of the United States. This includes 2.5 million middle school and 3.5 million high school aged youth. Since 2005, DFC grant award recipients have targeted areas that cover 48% of the US population.

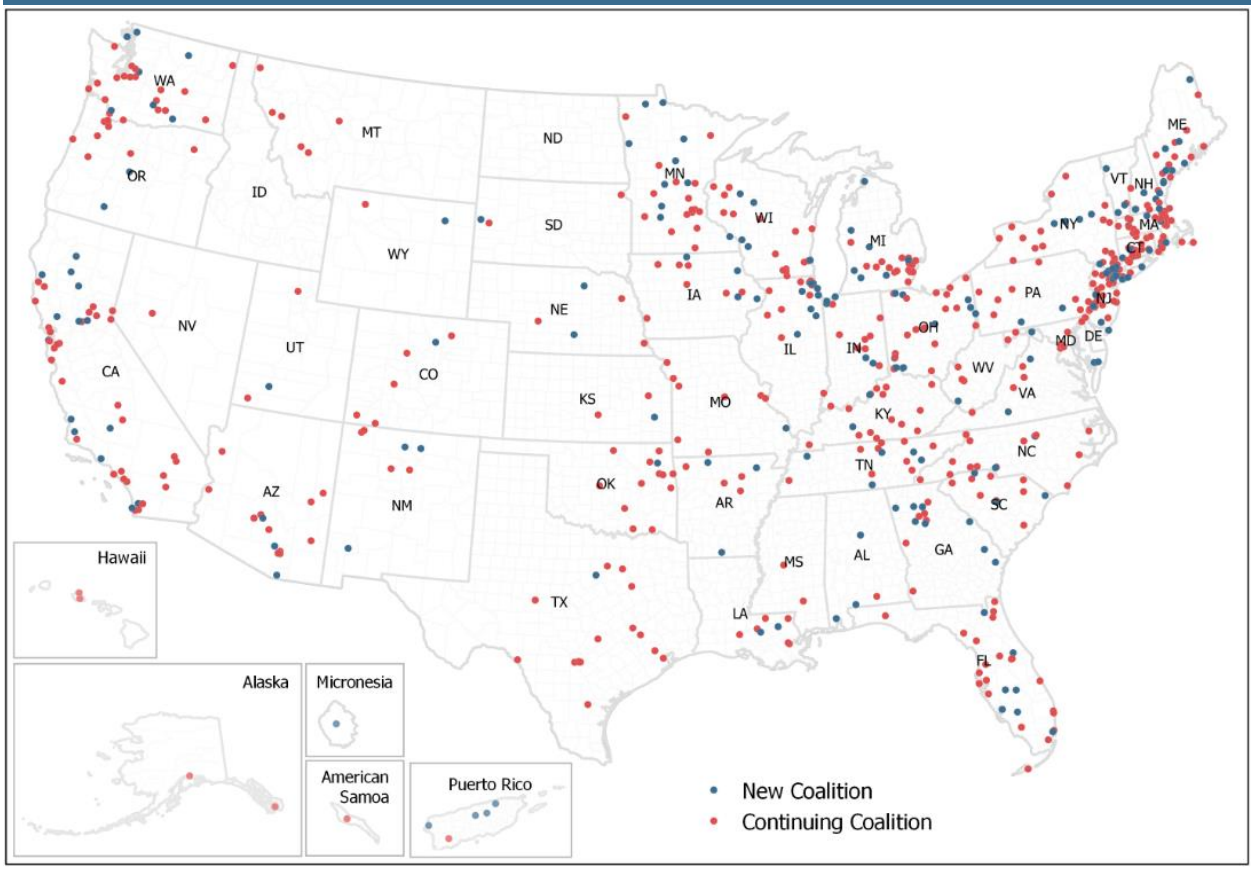
[8] These prevalence of non-use data are simply calculated by subtracting the prevalence of use percentage from 100%.

[9] DFC coalitions provide target zip code information in their grant application; this data is available for all 675 coalitions. For the core measures analyses, FY 2014 is a key comparison sample. In that year, ONDCP awarded 197 new DFC grants (i.e., 98 Year 1, 99 Year 6) and 463 DFC continuation grants for a total of 660 DFC grant award recipients.

[10] See United States Census 2010 data Age and Sex Table by zip code tabulation area (ZCTA) retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP1&prodType=table DFC coalitions provide zip codes while the US Census uses ZCTAs. These are mostly the same (see https://www.census.gov/geo/reference/zctas.html). Note that some zip codes reported as served by DFC coalitions are not found in the Census ZCTA, typically because they represent smaller communities. That is, census estimates reported here are likely a conservative estimate of potential reach of the DFC grant.

(19.7% of all middle school youth) and 3.5 million high school students between the ages of 15-18 (19.7% of all high school youth).[11] In 2016, one in five youth was living in a community with DFC. Since DFC grant award recipient data on catchment areas has been collected (i.e., 2005), DFC community coalitions have targeted areas with a combined population of approximately 149.2 million or 48% of the United States population. That is, nearly 1 in 2 persons in the US has lived in a community with a DFC coalition since 2005.

Figure 2. FY2015 DFC Grant Award Recipients are Located in Most States and in Three US Territories



Building Capacity to Prevent and Reduce Substance Use

DFC coalitions are required to engage community members from twelve sectors to conduct their work (see Figure 3 for the twelve sectors). Comprehensive community collaboration to reduce and prevent substance use among youth is a fundamental premise of effective community prevention, and the DFC program. This section examines DFC coalitions' efforts

[11] Age is used as an indicator of school level here as US census data are not collected by grade level.

at building community capacity to reduce and prevent substance use among youth as measured by sector membership. This includes the number of active members by sector and the average level of involvement of each sector's members. Next, an analyses of DFC coalitions' engagement with youth coalitions is presented. Finally, DFC's work to build community capacity is highlighted with respect to addressing opioids.

Number of Active Members

Almost all DFC coalitions (90%) met the requirement of having at least one current member from each of the twelve sectors.[12] Some members are more actively involved than others. Active members were defined as those that had attended at least one meeting during which coalition work was conducted in the past six months.[13] While most DFC coalitions identified at least one member for each sector, fewer (70%) reported having at least one active member from each sector. Generally, the average number of sector members and active members may fluctuate as members move into and out of the community or experience changes in ability to volunteer. For example, youth sector members are expected to change regularly as they graduate high school.

Figure 3 provides an overview of the median number of active members from each of the twelve sectors based on August 2016 data.[14] The median number of active members ranged from 1 to 4 per sector. On average, the youth and schools sectors had the highest median number of active members across DFC coalitions (4 active members each), followed by law enforcement agencies and parents (3 active members each). Median number of active members was lowest for the media and religious/fraternal organizations (1 active member) sectors.

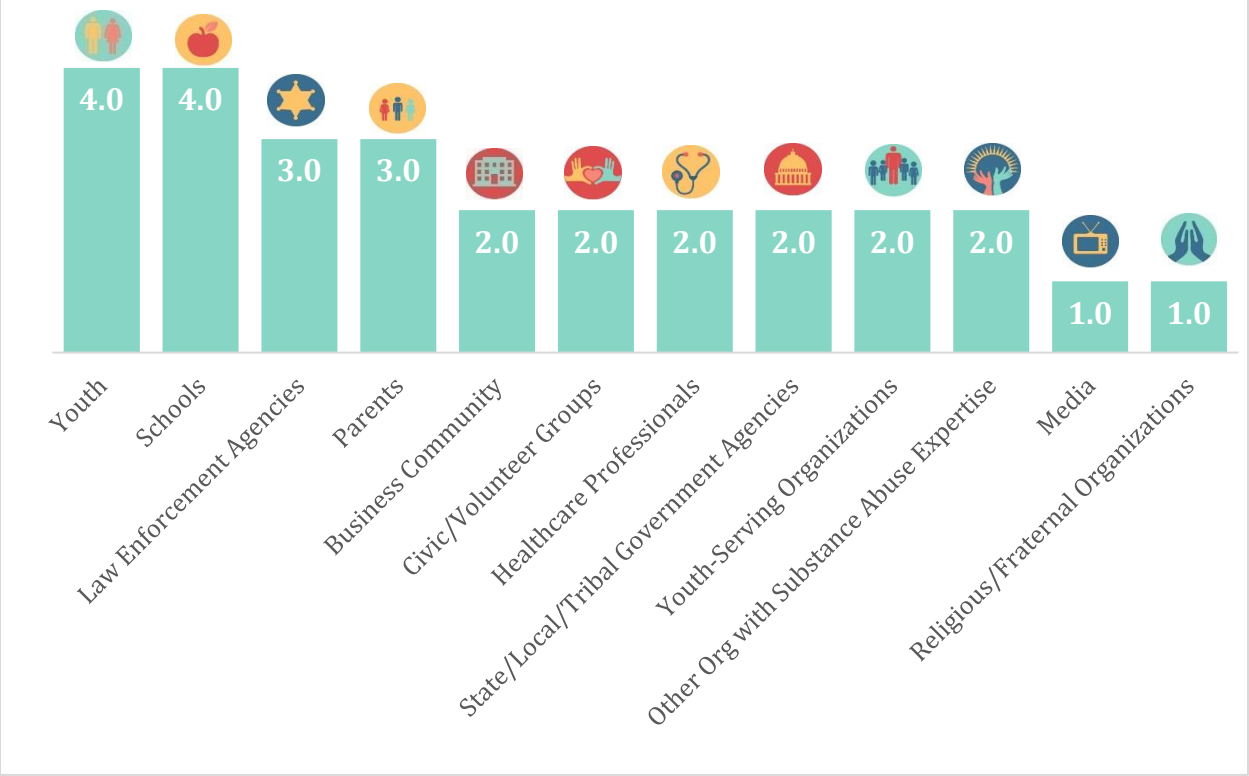
DFC Coalitions:
Building Community Capacity

Based on median number of staff (4) and active sector members (28), the 675 FY 2015 DFC coalitions mobilized **21,600** individuals to engage in youth substance use prevention work.

Summed across the 12 sectors, DFC coalitions reported involving a median of 28 total active members. Extrapolating from the median across all 675 FY 2015 DFC coalitions, DFC coalitions engaged approximately 18,900 active sector members.[15] DFC coalitions also rely on the work of paid and volunteer staff, reporting involving a median of 2 paid and 2 volunteer staff.

[12] SAMHSA Project Officers work with DFC coalitions who have challenges in meeting this grant requirement.
[13] The DFC National Evaluation team provided technical assistance to DFC coalitions regarding defining active members.
[14] Median is used here as a small percentage of DFC coalitions report very large numbers of active members, particularly for youth and parents, skewing the mean.
[15] While the summed median of active members was 28, if each coalition's total number of active members was summed, the median of summed total members was 36. Extrapolated across all 675 FY 2015 DFC approximately 24,300 active sector members were engaged in a community coalition. That is, 18,900 is likely a conservative estimate of coalition community capacity building.

Figure 3. DFC Coalitions Median Number of Actively Engaged Members from All Twelve Sectors: Youth, Schools, and Law Enforcement Agencies Sectors Contributed the Highest Average Number of Members



Notes: Numbers represent the median number of active members from each sector. The number of DFC coalitions reporting on number of active members by sector was 655.
Source: Membership Data, August 2016 Progress Report

The addition of paid and volunteer staff brings the total potential of individuals mobilized by the 675 FY 2015 DFC coalitions to work on youth substance use prevention to 21,600.

The median number of active members by sector was slightly lower in this report than in the 2014 DFC National Evaluation report.[16] One explanation for this may be the greater percentages of Year 1 and Year 2 DFC coalitions (30%) in the current report. Among the FY 2013 DFC coalitions included in the prior report, only 20% were in Year 1 or Year 2. Year 1 and Year 2 DFC coalitions may be in the early stages of building capacity.

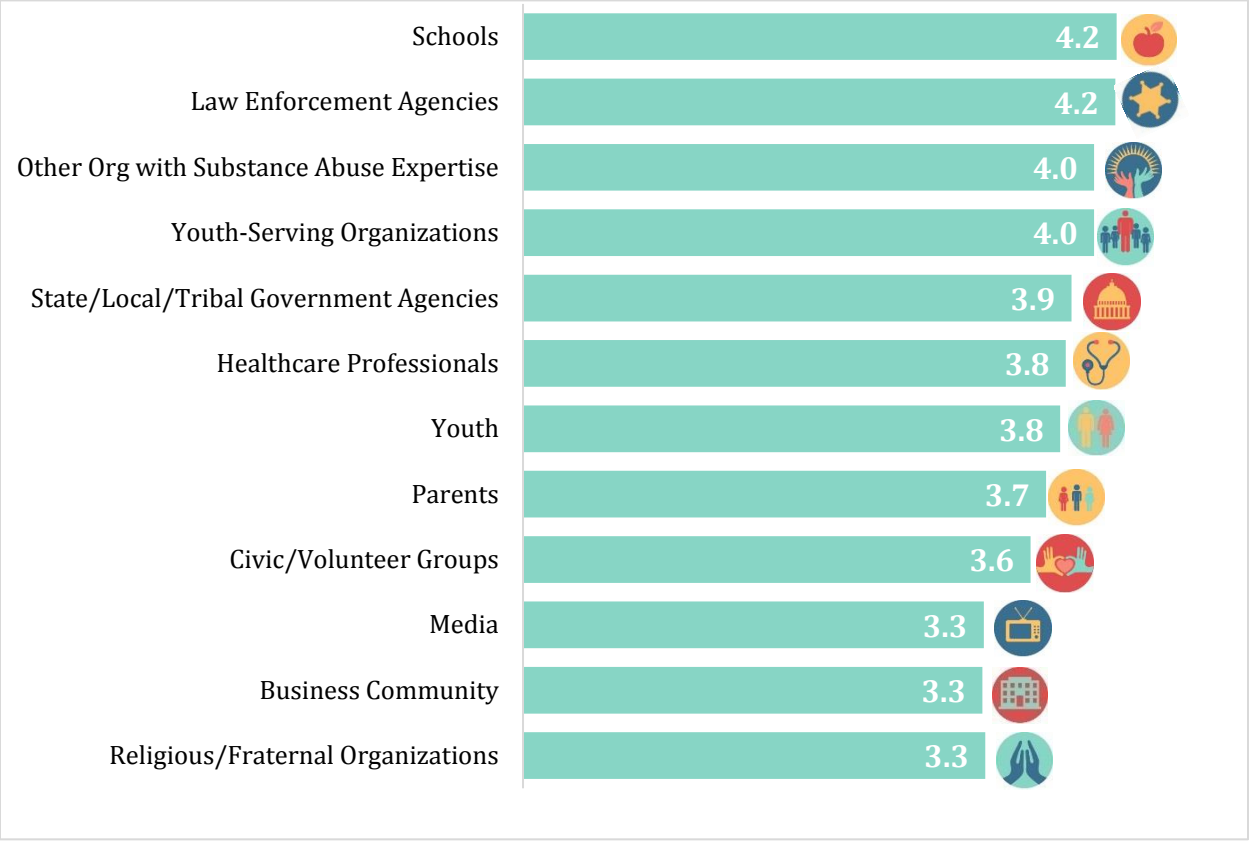
Involvement of Active Members

DFC grant award recipients were asked to indicate how involved on average active members from each sector were in coalition activities. Involvement was rated on a five point scale with 5 indicating very high involvement, 4 indicating high involvement, 3

[16] In August 2014, the median number of active members was 35 and the median number of staff was 5 (3 paid and 2 volunteer staff). DFC grant award recipients did not submit data in August 2015, therefore there is not a report associated with that time frame.

indicating medium involvement, 2 indicating some involvement, and 1 indicating low involvement (see Figure 4). On average, no sector was rated as being below medium involvement (none below 3). Four sectors were rated as between high and very high on involvement (4 to 5). The school and law enforcement sectors had the highest average level of involvement (4.2 each), followed by other organizations with expertise in substance use and youth serving organizations (4.0 each).

Figure 4. DFC coalitions' reported levels of sector involvement documented a broad range of "Very High" involvement with Law Enforcement and Schools rated highest on average



Notes: The number of DFC coalitions reporting on level of involvement by sector was rated on a five point scale with 5 indicating very high involvement, 4 indicating high involvement, 3 indicating medium involvement, 2 indicating some involvement, and 1 indicating low involvement. State/Local/Tribal Government Agencies with expertise in substance abuse.

Source: Membership Data, August 2016 Progress Report

DFC Youth Coalitions

Given the DFC program's focus on preventing youth substance use, youth engagement was examined more closely. Through site visits conducted from 2012 to 2015, the DFC National Evaluation Team identified youth coalitions as a promising strategy being used by many DFC coalitions who reported success in engaging youth in prevention.

In order to better understand how youth coalitions within a broader DFC coalition structure can enhance DFC work, the National Evaluation team added three questions to

the February 2016 progress report to evaluate the number of youth coalitions and their level of involvement. Specifically, DFC coalitions were asked to indicate (yes/no) if they had a youth coalition, and if yes, how often the youth coalition met and how involved the youth coalition was in planning prevention activities. Youth coalitions were defined as:

> **Youth Coalition:** A youth coalition is a group of youth who work together to plan and implement activities related to the mission of the full coalition. An adult coalition member serves as a mentor or leader, but the youth have key leadership roles. The youth coalition is integral to the full coalition, but generally meets independently.

February 2016 was the first time for all DFC coalitions to report on these items, with 66% of reporting coalitions at that time indicating having a youth coalition. Of the 653 DFC coalitions who reported on youth coalitions in the August 2016 progress report, 402 coalitions (61%) reported involving a youth coalition in their work, a slightly smaller percentage than in February 2016. Of these coalitions, 360 (90%) reported that the youth coalitions met at least once a month.[17] DFC coalitions also reported on the level of involvement of youth in their youth coalition using the same scale as sector members; average involvement for youth coalitions received a rating of 4.1 on the 1-5 scale, which falls within the high category (4). In addition, those DFC coalitions who reported having a youth coalition reported a significantly higher average level of youth sector involvement (4.2 [high involvement]) than those who reported not having a youth coalition (3.2 [just above medium involvement]).[18] The majority of DFC coalitions (76%) reported that these youth coalitions are highly or very highly involved in coalition planning and activities.

Addressing Opioids

A primary goal of DFC is to establish and strengthen collaboration among the twelve sectors in order to support the efforts of community coalitions working to prevent and reduce substance use among youth. DFC coalitions are encouraged to focus on building capacity to identify local problems and address them with local solutions. One way to understand the extent to which DFC coalitions are meeting this goal is to examine how they address new substance challenges that arise in their communities. The substance use issue that received the most attention nationally in 2016 was opioid use and associated opioid deaths, often referred to as the opioid epidemic.[19] The DFC National Evaluation team examined data in the August 2016 progress reports for indications that DFC coalitions were responding to this new challenge by addressing opioids. At least one coalition in each of 38 states/territories (73% of all states/territories with at least one DFC) mentioned

[17] 47.8% met once every 1-2 weeks while 41.8% met once a month. Another 4.5% met once every two months while 6.0% of those with youth coalitions reported they met only 1-2 times in the past six months.

[18] $t(652)=-10.8$, $p < .001$

[19] For additional information on the opioid epidemic, see CDC (2016). Drug overdose deaths in the United States Continue to increase in 2015. https://www.cdc.gov/drugoverdose/epidemic/. For additional CDC data, please see: Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov

opioids in an open text field. Preliminary findings and quotes from nine site visits conducted from January to June 2017 are also presented (see also Appendices B and C for additional highlights and potential promising practices for addressing opioids).[20] The data support that DFC coalitions have, in fact, built capacity to at least begin to address this challenge. During site visits focused on addressing opioids, participants often noted that having a DFC coalition facilitated collaboration on the issue that would not otherwise have been possible.

In FY 2015, 87.6% of the DFC coalitions indicated that they were targeting heroin, prescription drugs (including prescription opioids) or both in their list of top 5 substances targeted. Perhaps the most consistent strategy engaged in by DFC coalitions is their work associated with prescription drugs. DFC coalitions engaged in educating the community regarding risks of prescription opioids and reducing access to prescription drugs by providing prescription drug take-back boxes in the community and/or holding prescription drug take-back events. In fact, almost all DFC coalitions (94%) report having a prescription drug take-back event in their community and most of these occur as a result of the work of the DFC coalition (67%). DFC coalitions played a key role in addressing concerns around prescription drug disposal events as well as supporting and promoting them when they do occur. As one coalition leader noted during a site visit, "We've been working for two years trying to get a drug take back box there and we finally have that so now it's just a matter of

Coalition Site Visit Voices: Building Capacity to Address Opioids

"We've been a coalition for over ten years now and it's been run differently over the years but ever since we got DFC funding it's really been about . . . a coordinated response to really bringing the 12 sectors together. I think that's something that prior to [the DFC coalition] hadn't been done. People worked in their silos on the issue, we had law enforcement working on enforcement. We had [local organization] doing prevention. The hospital working on their end but we never really had these sectors working together. So I think once [the DFC coalition] really got going that really began to happen."

"What's so great about the coalition, there's somebody to beat that drum. There is an organized cooperative collaborative partnering opportunity to facilitate conversations around drug use and how that affects our youth and how that affects our community. So DFC has been really an integral part of that. If that drum didn't exist I'm not so sure there would've been a mechanism in our community through which we all could've facilitated constructive and positive conversation . . . what this has done is it's allowed people a process through which to do that collaboratively and consistently. If everybody around this table had his or her own idea and we went off on our own direction and we did that well then we lack cohesiveness, we lack the ability to leverage resources from each other and I think that's what DFC has really done it has allowed us as a community to leverage resources in a way that's consistent and productive."

"What the coalition has been able to do was to raise visibility and awareness and start a conversation which are all things that attack stigma and the fear to ask for help, either from your minister or your physician or your school or police or whomever. The more visible we become as a group, that's going to increase."

[20] Some of this analyses involved an examination of open-text fields to look for mentions of opioids. Some DFC coalitions who are working on this issue may not have noted this in open-text fields.

getting more information out to the community of 'you can take your drugs there' so I think we're pretty excited about that." Another site visit coalition had organized and sponsored nine local education workshops, "Opioid Overdose Prevention Series," educating over 400 healthcare and social services practitioners. DFC coalitions reported developing and conducting education and media awareness campaigns, particularly around the issue of keeping prescription drugs locked and inaccessible to youth. Finally, DFC coalitions have engaged with both the medical community and with other sectors of the community regarding responsible prescribing and monitoring, especially when prescribing opioids.

As found on site visits, DFC coalitions built capacity to address opioids by including new community sectors beyond the initial twelve identified by DFC. One example is working with athletic program staff, athletes, and their families regarding risks associated with opioid use following an injury or surgery. Several coalitions also noted new engagement with maternal care providers, child protective services and agencies engaged with work with children impacted by family engagement in substance use. In one community, waste management started attending DFC meetings following concerns from waste management staff regarding their engagement with substances (e.g., needle cleanup, cleaning up methamphetamine labs, and cleaning up after parties in isolated community spaces).

Addressing opioids by building capacity is also clear in the engagement of DFC coalitions in a range of other activities. This includes either forming or working with a task force (or partnership) to address opioids. These task forces bring together key stakeholders specifically to discuss the extent of the issue locally and to develop strategies to address the issue. During one visit, the DFC national evaluation team attended a district attorney task force meeting where the participating DFC site noted that there were three DFC coalitions in attendance and the work of a fourth DFC from another region in the state was introduced. Similarly, DFC coalitions attend, plan and conduct informational summits, forums and town halls. DFC coalitions are not just reacting to the opioid crisis, they are also working to prevent local impacts when their community has not yet been significantly impacted by opioids directly.

Strategy Implementation

A primary purpose of collaboration across sectors who traditionally work independently is leveraging skills and resources in planning and implementing prevention strategies. To assess what DFC coalitions are doing, 41 individual kinds of prevention activities have been identified. They have been grouped into the seven strategies for community change, with any given activity linked to a single strategy.[21] The seven strategies are providing

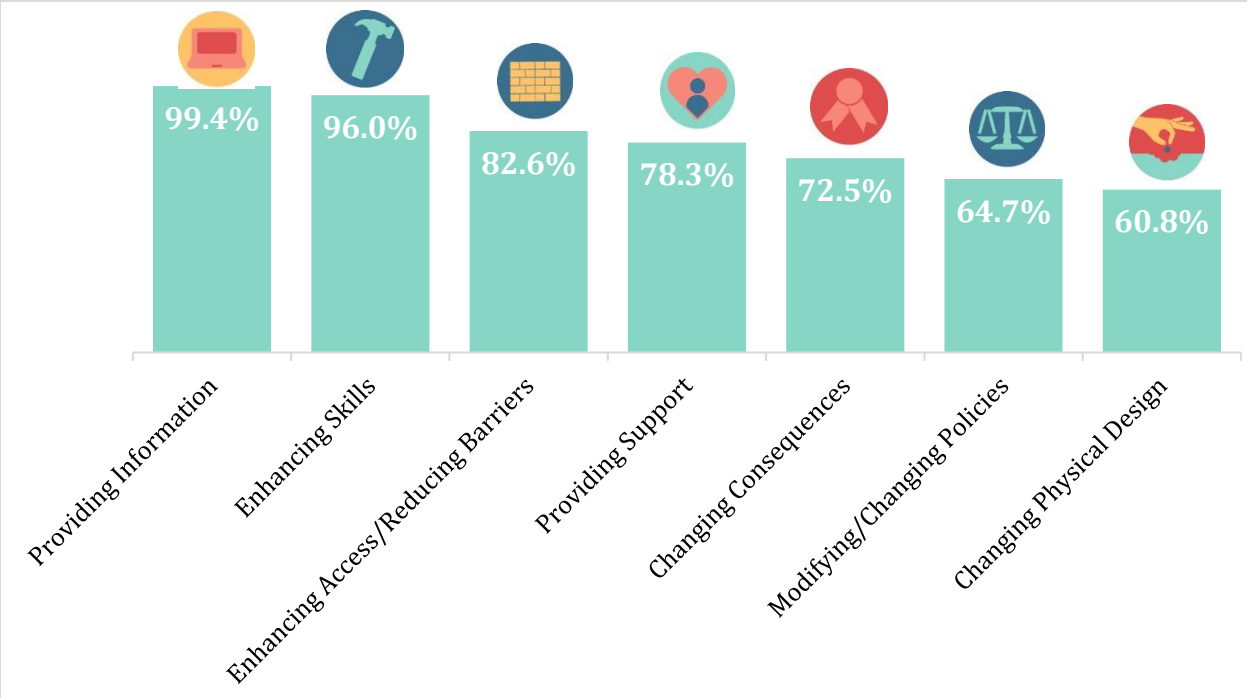
[21] See CADCA publication on the seven strategies http://www.cadca.org/resources/coalition-impact-environmental-prevention- CADCA derived the strategies from work by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre http://www.udmo.com/powerup/faq/7%20strategies.pdf for additional information. Retrieved on 11/4/16.

information, enhancing skills, providing support, enhancing access/reducing barriers, changing consequences, changing physical design, and modifying/changing policies. This section of the 2016 end-of-year report provides an overview of the specific activities and strategies coalitions have implemented and reported in the August 2016 Progress Report. It also provides information on the numbers of activities and community members they reach. Finally, the engagement of youth in activities implemented by DFC coalitions is highlighted.

Overview: Implementation of Strategies

Activities of DFC coalitions reported in August 2016 document the comprehensive presence of DFC coalitions in their communities (see Figure 5). Nearly all (99.4%) of the 655 DFC coalitions that submitted an August progress report indicated they had engaged in information dissemination activities. Nearly as many (96.0%) provided services related to enhancing skills. These types of activities tend to build credibility in the community, identify the coalition as a reliable source of information and serve to build capacity both by informing people about the coalition and training community members to engage in prevention work directly.

Figure 5: Percentage of DFC Coalitions Engaged in Each of the Seven Strategies for Community Change



Notes: The number of DFC grant award recipients reporting activity data in the February 2016 Progress Report was 669. Outliers beyond 3 standard deviations were removed.
Source: Activity Data, February 2016 Progress Report

Slightly lower percentages of DFC coalitions engaged in activities to promote access/reduce barriers to prevention and treatment services (82.6%), provide support (78.3%), and

change consequences (72.5%). DFC coalitions were least likely to report engaging in activities to educate and inform on policy/law changes to decrease substance use and associated negative behaviors (64.7%) and to change physical environments to decrease opportunities for and encouragement of substance use (60.8%).

Providing Information

Activities in this strategy provide individuals with information related to youth substance use, preventing youth substance use, and the consequences of youth substance use. Examples include public service announcements, brochures, and presentations during community meetings. Providing information activities are one way that DFC coalitions establish themselves in the community as experts on youth and substance use/substance use prevention. Nearly all DFC coalitions (99.4%) reported engaging in activities to provide information to community members (see Table 2).

Most DFC coalitions (92.2%) disseminated prevention materials (including brochures and flyers). In addition, some 127,912 media spots were advertised via print, billboard, television, radio, and other methods by 530 DFC coalitions (80.9%) and nearly half of the coalitions (45.2%) reported posting new materials on coalition websites that garnered 450,409 hits.

In addition to providing general prevention information via print and electronic media, DFC community coalitions also directly engaged youth and adults in their communities. For example, DFC coalitions reported that they held 8,206 face-to-face information sessions. The sessions reached 128,331 adults and 153,131 youth. DFC coalitions also held or contributed to 1,954 special events that served 434,366 adults and 324,393 youth.

Coalition Voices: Providing Information

"In an effort to provide information and to reduce underage drinking, the . . . youth coalition has distributed Parents Who Host cards and posters to local business owners throughout the school year. The goal has been to continue to educate parents on the legal and health consequences of underage drinking parties through "Parents Who Host Lose the Most" public awareness campaign-there were over 1,000 facts cards distributed in 2016 as well as the continuation of the billboard campaign."

"Our most notable accomplishments during this period included . . . an app (which will provide substance abuse resources and education) and our . . . town hall meetings that use social media to communicate and gather and share information. The coalition was able to generate a lot of interest for the campaign and town hall which increased attendance at the event and more interest in the coalition."

"Our youth and adult media campaigns have been localized with stats and pics and we have materials all over town, at the local movie theatre and going out in the mail."

Providing information is the most pervasive activity in which DFC coalitions engage. In this reporting period more than half (53.7 %) of coalitions estimated that providing information was the strategy on which staff spent most of their effort. This effort creates a broad presence in the community on which more focused activities can be built. Together, coalitions reported 10,160 events which an estimated 912,349 members came into contact with their coalition. For those indirect

information channels (social networking and website hits) for which individual exposure could be estimated, coalition information reached 5,128,007 community members.[22]

Table 2: DFC Coalitions' Accomplishments Related to Providing Information

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Completed Activities	Number of Adults Served	Number of Youth Served
Information Dissemination: Brochures, flyers, posters, etc. distributed	604	92.2%	--[a]	--[b]	--[b]
Media Coverage: TV, radio, newspaper stories covering coalition activities	537	87.8%	15,421	--[b]	--[b]
Informational Materials Produced: Brochures, flyers, posters, etc. produced	556	84.9%	133,740	--[b]	--[b]
Direct Face-to-Face Information Sessions	562	85.8%	8,206	128,331	153,131
Media Campaigns: Television, radio, print, billboard, bus or other posters aired/placed	530	80.9%	127,912	--[b]	--[b]
Special Events: Fairs, celebrations, etc.	524	80.0%	1,954	434,366	324,393
Social Networking: Posts on social media sites (e.g., Facebook, Twitter)	575	87.8%	87,690	4,019,053 followers	658,545 followers
Information on Coalition Website: New materials posted	296	45.2%	4,620	450,409 hits[c]	--[b]
Summary: Providing Information	**651**	**99.4%**	**379,543**	**N/A**	**N/A**

Notes: In the August 2016 Progress Report, 655 DFC grant award recipients reported data. In some cases, the same youth or adults may have participated in multiple activities. Outliers beyond 3 standard deviations were removed.
[a] DFC coalitions reported distributing a total of 861,030 brochures, flyers, posters, etc.
[b] Data on number of people served was not reported as it could not be collected consistently and reliably by all DFC coalitions.
[c] Number of web hits. Note that some DFC coalitions report they are unable to track hits.
N/A = Not Applicable
Source: Activity Data, August 2016 Progress Report

[22] This overall estimate is data-based but inevitably inexact. For example, some participants in face-to-face information sessions may have attended more than one event during the reporting period; distributed materials may not have been read, or it may have been circulated and read by many community members. In any case, a coalition community presence is established.

Enhancing Skills

Coalition Voices: Enhancing Skills

"Four school districts sent students to a day-long leadership retreat where they engaged with students from other schools and came up with a county wide social norms message based on YRBS data. . . . LCAT staff attended trauma sensitive classroom training with an understanding of the strong link between a history of trauma and future substance abuse."

"We created a program to further educate those cited for serving underage youth in our compliance checks. We held our first class and the feedback from servers was beyond positive; they said they learned so much more than the online course the bars typically use . . . We have been trying to get this in place for years and finally have it, with support of law enforcement, the judges and the district attorney."

The purpose of activities in this strategy is to enhance the skills of participants, members, and staff regarding substance use prevention. Examples include youth conferences, parenting workshops, staff training, and technical assistance (see Table 3). The vast majority of DFC coalitions (96.0%) engaged in activities related to enhancing skills. Providing youth education and training programs was the most common activity completed by coalitions with 516 (78.8%) delivering some 5,990 sessions to 158,232 youth. Half (52.2%) of DFC community coalitions reached 51,009 parents through parent training sessions about drug awareness, prevention strategies, and parenting skills. Training was also provided to 51,735 additional community members, 14,864 teachers, and 9,203 workers at businesses that sell alcohol or tobacco.

Other than providing information, DFC coalitions overall devoted more staff effort on enhancing skills than any other strategy. More than half (50.2 %) of coalitions reported that enhancing skills was one of the top two strategies receiving staff effort. Overall, they recorded reaching 285,043 community members in these interpersonal training contacts.

Providing Support

DFC coalitions provide support for people to participate in activities that reduce risk or enhance protection.[23] Examples include providing substance-free activities, mentoring programs, and support groups (see Table 4). Most DFC coalitions (78.3%) engaged in activities related to providing support. More than half of the DFC coalitions (57.9%) sponsored or supported drug-free alternative social events, such as after prom events, attended collectively by 113,435 youth. DFC coalitions also supported 1,372 youth organizations and clubs serving 17,406 youth, and an additional 786 youth recreation

[23] DFC coalitions must comply with all Federal policies and regulations describing allowable and unallowable grant expenditures. In addition, the DFC Support Program has specific funding restrictions. DFC grant funds may not necessarily fund all of the activities examples provided for each of the Strategies for Community Change. See http://www.samhsa.gov/sites/default/files/grants/pdf/sp-15-001-mod.pdf for a sample DFC grant application describing funding limitations.

Table 3: DFC Coalitions' Accomplishments Related to Enhancing Skills

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Completed Activities	Number of Adults Served	Number of Youth Served
Youth Education and Training: Sessions focusing on providing information and skills to youth	516	78.8%	5,990	N/A	158,232
Community Member Training: Sessions on drug awareness, cultural competence, etc. directed to community members, (e.g., law enforcement, landlords)	407	62.1%	1,491	51,735	N/A
Parent Education and Training: Sessions directed to parents on drug awareness, prevention strategies, parenting skills, etc.	342	52.2%	1,282	51,009	N/A
Business Training: Sessions on server compliance, training on youth-marketed alcohol products, tobacco sales, etc.	241	36.8%	751	9,203	N/A
Teacher Training: Sessions on drug awareness and prevention strategies directed to teachers or youth workers	239	36.5%	593	14,864	N/A
Summary: Enhancing Skills	**629**	**96.0%**	**10,107**	**126,811**	**158,232**

Notes: In the August 2016 Progress Report, 655 DFC grant award recipients reported activities. In some cases, the same youth or adults may have participated in multiple activities. Outliers beyond 3 standard deviations were removed.
N/A = Not Applicable
Source: Activity Data, August 2016 Progress Report

programs with 24,274 participants. DFC coalitions held or supported 784 community service events providing opportunities for family and youth involvement. More than 83,500 youth and adults participated. DFC coalitions also supported 1,143 youth and family support groups helping 7,377 participants. In this reporting period, coalitions supported opportunities for protective activities that served 285,043 community members. More than half (55.5%) of coalitions reported that supporting these activities was one of the top three strategies on which staff effort was spent.

Coalition Voices: Providing Support

"We also provide alternative activities for youth . . . to possibly curb substance abuse or high risk behavior. This includes activities on high risk nights such as prom, graduation, Halloween, and New Year's Eve. . . Every week we meet with our after school, anti-drug club that focuses on at risk youth . . . This is a mentoring group where we take children who come from homes that suffer from substance abuse issues and give them a safe place to come every week."

Table 4: DFC Coalitions' Accomplishments Related to Providing Support

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Completed Activities	Number of Adults Served	Number of Youth Served
Alternative Social Events: Drug-free parties, other alternative events supported by the coalition	379	57.9%	1,664	62,311	113,435
Youth/Family Community Involvement: Community events held (e.g., neighborhood cleanup)	223	34.0%	784	38,923	44,644
Youth Recreation Programs: Recreational events (e.g., athletics, arts, outdoor activities) supported by coalitions	164	25.0%	786	7,396	24,274
Youth/Family Support Groups: Leadership groups, mentoring programs, youth employment programs, etc. supported by coalitions	110	16.8%	1,143	4,037	3,340
Youth Organizations: Clubs and centers supported by coalitions	121	18.5%	1,372	8,309	17,406
Summary: Providing Support	**513**	**78.3%**	**5,749**	**120,976**	**203,099**

Notes: In the August 2016 Progress Report, 655 DFC grant award recipients reported activity data. In some cases, the same youth or adults may have participated in multiple activities. Outliers beyond 3 standard deviations were removed.
Source: Activity Data, August 2016 Progress Report

Enhancing Access/Reducing Barriers

The purpose of activities in this strategy is to improve the ease, ability, and opportunity for community members to utilize systems and services providing substance use prevention and treatment resources. Examples include providing transportation to treatment; providing childcare; reducing the availability of tobacco, alcohol, and drugs; and cross-cultural outreach, e.g. language translation (see Table 5).[24] A large majority of DFC coalitions (82.6%) engaged in activities related to enhancing access/reducing barriers.

The activity within this strategy used by the most DFC coalitions (67.5%) were intended to reduce home and social access.[25] As noted in the section on addressing opioids, one example of this type of activity are community prescription drug take-back programs which occur in 94% of DFC coalition communities (see also Community Assets section) with 2 in 3 DFC coalitions (67%) reporting that prescription drug take back programs were

[24] Please see footnote 22 regarding limitations on uses of DFC funding. DFC grant funds may not necessarily fund all of the activities examples provided for each of the Strategies for Community Change.
[25] Many prescription drug take-backs involve drop boxes that are not monitored on a 24/7 basis, making it difficult to estimate the number of adult/youth participants.

introduced in the community following efforts of the DFC coalition. More than a third of DFC coalitions (35.1%) reported increasing access to substance use services. Nearly 50,000 adults and over 30,000 youth were referred to substance use services. Thirty percent of DFC coalitions engaged in activities to improve access through culturally sensitive outreach (e.g., providing services and materials in languages other than English). Nearly 40,000 adults and youth received supports such as transportation or access to childcare that facilitate participation in prevention and treatment.

Coalition Voices:
Enhancing Access/Reducing Barriers

"Our coalition is thrilled with our new naloxone initiative. This was the first coalition-led naloxone initiative in the state, and we were able to put this opioid overdose reversal drug in the hands of 200 law enforcement officers, 40 firefighters, and 30 school nurses. 15 lives have been saved in the last 6 months. Since our initiative began, we have been working with dozens of counties, communities and departments across the state to help them replicate our program. A staff member is also now serving on the state naloxone advisory board."

"The Medicine Take Back Day in April was a success . . . Over 500 people took part in the event, with 12,372 controlled pills collected and 2940 lbs. of medications collected"

"To date, the coalition has located a contractor and successfully translated the resources into 14 languages."

Table 5: DFC Coalitions' Accomplishments Related to Enhancing Access/Reducing Barriers

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Adults Served	Number of Youth Served
Reducing Home and Social Access: Adults and youth participating in activities designed to reduce access to alcohol and other substances (e.g., prescription drug take-back programs)	442	67.5%	854,924	221,085
Improve Access through Culturally Sensitive Outreach: People targeted for culturally sensitive outreach (e.g., multilingual materials)	194	29.6%	466,052	50,386
Increased Access to Substance Use Services: People referred to employee assistance programs, student assistance programs, treatment services	230	35.1%	47,938	30,831
Improved Supports: People receiving supports for enhanced access to services (e.g., transportation, child care)	89	13.6%	19,821	19,920
Summary: Enhancing Access/Reducing Barriers	**541**	**82.6%**	**1,388,735**	**322,222**

Notes: In the August 2016 Progress Report, 655 DFC grant award recipients reported activity data. Outliers beyond 3 standard deviations were removed.
Source: Activity Data, August 2016 Progress Report

Changing Consequences

Activities in the changing consequences strategy promote community practices that encourage positive organizational or individual behaviors to reduce risk for substance use and resulting harms, and discourage behaviors that increase this risk. For example, public recognition of business practices that reduce risk for harmful substance use (e.g., passing compliance checks) is an incentive to adopt behaviors that reduce risk; increasing surveillance for substance use violations (e.g., DUI checks) is a disincentive. Table 6 presents an overview of the number of DFC coalitions that conducted activities related to changing consequences and businesses affected by these activities. Nearly three-fourths of the DFC coalitions (72.5%) engaged in activities related to changing consequences.

Coalition Voices: Changing Consequences

"... Annual Recognition Luncheon for Youth and Collaborators. This year the event had 85 attendees that included youth, collaborators, and community partners ... The gala was to celebrate the positive impact ... in the community, ... There was a red carpet and photos taken in front of the [coalition] logos backdrop and a showcase of all the successes of the coalition. During the celebration, awards were giving to some of the individuals that have demonstrated leadership, excellence and promoted community change through their involvement."

More than half (54.0%) of DFC coalitions engaged in activities focused on strengthening enforcement of existing laws; 35.6% strengthened surveillance activities. DFC coalitions reported more engagement in recognizing positive business behavior than in publicizing negative business behavior. Specifically, more than a third (34.7%) of DFC coalitions implemented recognition programs that reward local businesses for compliance with local

Table 6: DFC Coalitions' Accomplishments Related to Changing Consequences

Activity	Number of DFC Coalitions Engaged[a]	Percentage of DFC Coalitions Engaged	Number of Businesses Reached
Strengthening Enforcement (e.g., DUI checkpoints, shoulder tap, open container laws)	354	54.0%	N/A
Strengthening Surveillance (e.g., "hot spots," party patrols)	233	35.6%	N/A
Recognition Programs: Businesses receiving recognition for compliance with local ordinances (e.g., pass compliance checks)	227	34.7%	6,339
Publicizing Non-Compliance: Businesses identified for non-compliance with local ordinances	85	13.0%	5,071
Summary: Changing Consequences	**475**	**72.5%**	**11,410**

Notes: In the August 2016 Progress Report, 655 DFC grant award recipients reported activity data. Outliers beyond 3 standard deviations were removed.
[a] Data on number of people served was not collected since it could not be collected consistently and reliably by all grant award recipients.
N/A = Not Applicable
Source: Activity Data, August 2016 Progress Report

ordinances linked with the sale of alcohol and tobacco. While fewer DFC coalitions (13.0%) engaged in activities to publicly identify establishments that were noncompliant with local ordinances only a slightly smaller number of business were reached by the two approaches. During this reporting period 6,339 businesses received recognition for compliance; 5,071 were publically identified for non-compliance.

Educating and Informing about Modifying/Changing Policies

Educating and informing about modifying/changing policies strategy involves engaging in activities to educate and inform the community concerning effects of current and potential laws, rules, policies, and practices influencing substance use and accompanying harmful outcomes for the community (see Table 7).[26] Examples of activities include educating about school drug testing policies and local use ordinances. Close to two thirds (64.7%) of DFC coalitions engaged in activities related to educating or informing about modifying/changing policies that were associated with a change. Educating or informing related to school policies were most common with 27.8% of DFC coalitions engaged in this activity to successfully bring change to 131 drug-free school policies. DFC coalitions also successfully educated about laws/policies concerning: underage use, possession, or behavior under the influence (88 policies); access to treatment or prevention services as an alternative to sentencing (75 policies); drug-free workplaces (55 policies); sales restrictions (49 policies); parental liability/enabling behaviors (38 policies); and supplier advertising/liability (29 policies).

Coalition Voices:
Educating and Informing about Modifying/Changing Policies

"[City] Town Council passed a local zoning ordinance that would ban any marijuana businesses in the town. . . . The coalition was cited as a source of information and was applauded for our role as a resource to the community. One town council member quoted from our monthly e-newsletter as part of his statement supporting the ordinance."

"Two of our coalition members were able to successfully work with 3 local radio/broadcasting studios to amend the time of day when tobacco, vaping, e-cigs commercials can run."

"Worked with EMS to adopt internal policy to carry home medication disposal kits on all emergency response vehicles and distribute to patients as determined appropriate."

[26] DFC coalitions are legally prohibited from using Federal dollars for lobbying and are informed of this in their grant terms and conditions. As such, costs for lobbying cannot be calculated as contributing to the required match. For more information refer to Restrictions on Grantee Lobbying (Appropriations Act Section 503; see https://www.hhs.gov/grants/grants/grants-policies-regulations/lobbying-restrictions.html).

Table 7: DFC Coalitions' Accomplishments Related to Educating and Informing about Policies/Laws

Activity: Laws or Policies Passed/Modified Concerning:	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Policies Passed/ Modified
School: Drug-free schools	182	27.8%	131
Citizen Enabling/Liability: Parental liability or enabling	118	18.0%	38
Underage Use: Underage use, possession, or behavior under the influence	134	20.5%	88
Supplier Promotion/Liability: Supplier advertising, promotions, or liability	85	13.0%	29
Cost: Cost (e.g., alcohol taxes/fees, tobacco taxes)	69	10.5%	31
Treatment and Prevention: Sentencing alternatives to increase treatment or prevention	97	14.8%	75
Sales Restrictions: Restrictions on product sales	93	14.2%	49
Workplace: Drug-free workplaces	60	9.2%	55
Outlet Location/Density: Density of alcohol outlets	49	7.5%	18
Summary: Modifying/Changing Policies	**424**	**64.7%**	**929**

Notes: In the August 2016 Progress Report, 655 DFC grant award recipients reported activity data. Outliers beyond 3 standard deviations were removed.
Source: Activity Data, August 2016 Progress Report

Changing Physical Design

For this strategy, activities involve changing physical features of the community environment to reduce risk or enhance protection. Examples of activities in this area include cleaning up blighted neighborhoods, adding lights to a park, and regulating alcohol outlet density (see Table 8).[27] Physical design activities were engaged in by less than two-thirds of DFC coalitions (60.8%), less than any other strategy. Identifying physical design problems was the activity used by most coalitions (30.4%); nearly as many worked on improving signage or advertising by suppliers (26.3%). More than 700 physical design problems were identified and over 1,000 improvements in signage, advertising, or displays corresponding to alcohol or tobacco sales were reported. In addition, DFC coalitions completed 234 neighborhood cleanup and

Coalition Voices: Changing Physical Design

"We created 40 community changes made to [local park], including physical design changes of increased signage, video monitoring, eliminating brush piles, and increasing visibility to bike bath by removing shrubs."

"[Coalition] worked with local governments to declare certain areas as drug free and post signs indicating the drug free area. [Coalition's] logo was added to each of the signs. . . . Law enforcement agencies increased patrols during certain hours and certain events."

[27] Please see footnote 22 regarding limitations on uses of DFC funding. DFC grant funds may not necessarily fund all of the activities examples provided for each of the Strategies for Community Change.

Table 8: DFC Coalitions' Accomplishments Related to Changing Physical Design

Activity	Number of DFC Coalitions Engaged	Percentage of DFC Coalitions Engaged	Number of Completed Activities
Identifying Physical Design Problems: Physical design problems (e.g., hot spots, clean-up areas, outlet clusters) identified through environmental scans, neighborhood meetings, etc.	199	30.4%	731
Improved Signage/Advertising by Suppliers: Suppliers making changes in signage, advertising, or displays	172	26.3%	1,193
Cleanup and Beautification: Clean-up/beautification events held	130	19.8%	234
Encourage Designation of Alcohol-Free and Tobacco-Free Zones: Businesses targeted or that made changes	97	14.8%	297
Identify Problem Establishments: Problem establishments identified (e.g., drug houses) and closed or modified practices	43	6.6%	123
Improved Ease of Surveillance: Areas (public places, hot spots) in which surveillance and visibility was improved (e.g., improved lighting, surveillance cameras, improved line of sight)	67	10.2%	306
Summary: Changing Physical Design	**398**	**60.8%**	**2,884**

Notes: In the August 2016 Progress Report, 655 DFC grant award recipients reported activity data. Outliers beyond 3 standard deviations were removed.
Source: Activity Data, August 2016 Progress Report

beautification events, encouraged 297 businesses to designate alcohol and tobacco free zones, and improved 306 public places to facilitate surveillance (e.g., improving visibility of "hot spots" for substance dealing or use).

Summary of Coalition Strategy Implementation

DFC coalitions provide a broad range of activities that recognize and address the complex and inter-related factors that influence initiation and degree of substance use among youth. The strategies encompass broad information dissemination, efforts to enhance individual skills and inter-personal supports that reduce substance use, and changing the institutional and behavioral environmental factors that contribute to or mitigate substance use among youth. Each DFC coalition is encouraged to focus on a comprehensive range of strategies that best addresses local needs and challenges—to find local solutions to local problems. The comprehensiveness of these strategies is important because substance use has no one cause. DFC coalitions recognize and meet the need for comprehensive and complementary prevention activities to improve the likelihood that youth will have protective supports

that are associated with decreased initiation and ongoing engagement by youth in substance use.

The mix of community members/sectors engaged by DFC coalitions is further evidence of their comprehensive scope. While the focus is preventing substance use by youth, DFC coalitions also engage adults to make family and community environments more supportive of youth choosing to remain or become drug-free. In the most recent data, 655 coalitions documented in-person contact with close to six million adults. In addition, coalitions used public information outlets (e.g., public service announcements, news stories, brochures, posters, social media) to increase information and awareness in their communities.

The engagement data also documents implementation of complementary strategies that focus activities where they will have the greatest impact. Information activities, for example, document over ten times as many contacts with adults as with youth. Informed adults are critical to facilitating the community and family environmental changes that are critical to substance use prevention. Skills enhancement contacts typically differentiate youth and adult audiences because the skills needed by each concerning prevention are distinct. DFC coalitions also engage in activities that create opportunities for social interaction between adults and youth. An example of a complementary strategic orientation is the engagement of both adults (1,388,735) and youth (322,222) in activities aimed at increasing access and reducing barriers which includes programs such as prescription drug take-back events but also access to culturally appropriate community services (e.g., recovery services). Collectively, these contribute to family and community environments more protective of positive youth behavior (and substance use prevention).

Engaging Youth in DFC Implementation Strategies

These detailed data on activities and community participation demonstrate a particularly important principle of addressing youth substance use prevention at the community level. DFC coalitions are a strong example of working *with* youth, and providing opportunity for positive youth contribution and development, rather than solely doing things *for* or *to* youth. As noted in the section on DFC Youth Coalitions, 61% of DFC coalitions report having a youth coalition to engage active involvement of youth,

DFC Coalitions *Engagement with Youth*

Youth were involved with or directly impacted by a broad range of DFC Coalitions' activities. Examples include:

- **298,984** youth participated in training
- **179,376** youth participated in alternative social events
- **50,385** youth involved through youth recreation programs
- **25,498** youth involved through youth organizations
- **297,489** youth participated in activities to reduce home and social access
- **27.8%** of DFC coalitions educated/informed about 131 new school policies addressing substance use issues

and three fourths of these youth coalitions are highly or very highly involved in coalition planning and activities.

Across strategies, more DFC coalitions engaged in activities targeting youth than those targeting any other community group: alternative drug-free activities for youth were the most implemented enhancing support activity; reducing home and social access to substances was the most implemented enhancing access/reducing barriers activity; and more DFC coalitions focused on educating about school policies than on any other category of law and policy change. DFC coalition activities provide many opportunities for youth, families, and community members to work or play together. Many DFC coalitions reported anecdotally on the involvement of youth in activities across strategy types, indicating youth were the agents of change as well as the target of activities. In summary, DFC coalitions engage youth directly in building stronger and more positive community connections that again are associated with substance use prevention.

Core Measures Findings from the Outcome Evaluation

This section of the report provides findings related to changes in core measures outcomes from first report to most recent report.[28] Only the currently approved core measures are presented in this report. For core measures not changed or introduced in 2012, DFC coalitions have reported data from 2002 to 2016. For core measures approved in 2012, including peer disapproval and all outcomes for illicit use of prescription drugs, DFC coalitions have reported data between 2012 and 2016. Data were first analyzed including all available data from DFC coalitions since the inception of the grant. Next, data were analyzed including only the DFC coalitions funded in FY 2014.[29] Data analyses presented in this report describe changes in the core measures from available core measures data collected by the coalitions primarily from 2002 to 2015. The findings provide a reflection of the relationship between coalition activities and community outcomes. The data are presented visually using dot plots (see Appendix D for data presented in Tables).[30] Change in the core measure where the most recent report (green dot) is to the right of first report (gray dot) represents increased past 30-day prevalence of non-use, perception of risk/harm of use, and perception of parent and peer disapproval – changes in line with the goals of the grant. The farther apart the dots are, the more likely it is that the difference was significant, while the more overlap there is, the more likely it is that the difference was not significant.[31] The scale across all dot plots is from 50-100%.

Past 30-Day Prevalence of Non-Use

One of the key goals of the DFC grant is to prevent and reduce youth substance use. For all substances—for both middle school and high school age groups as well as for both all DFC coalitions since inception and FY 2014 DFC coalitions only—there was a significant increase in past 30-day prevalence of non-use (see Figure 6 and Table D.2, Appendix D). That is, within communities with a DFC coalition, more youth reported not using each of the core measure substances at most recent report than at first report.

Several aspects of the past 30-day prevalence of non-use data are worth noting. First, the majority of youth reported that they did not use each of the given core measure substances.

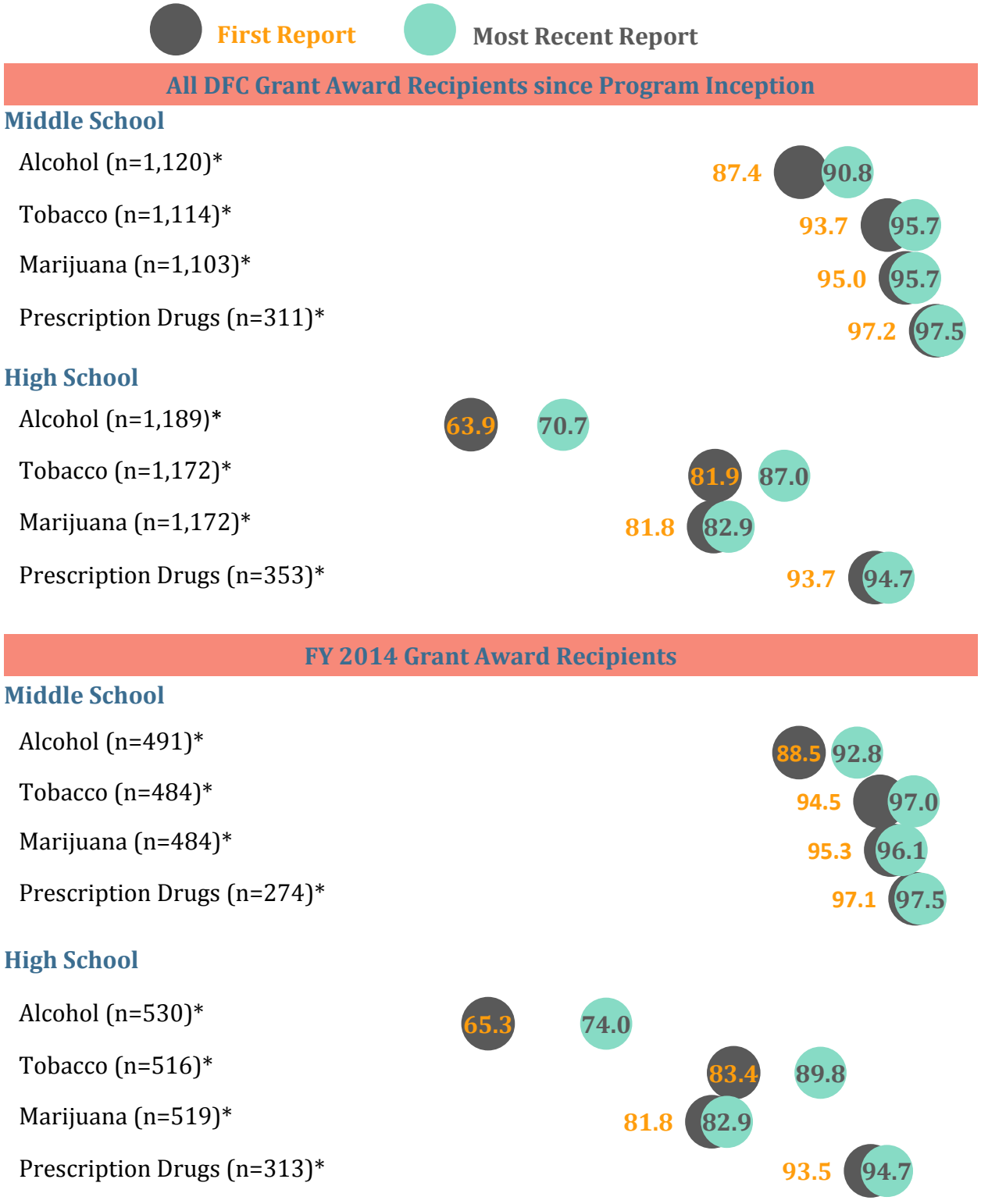
[28] Data were analyzed using paired t-test. First and most recent outcomes were weighted based on number of students surveyed. Outliers with change scores greater than three standard deviations were excluded from the analyses. Significance is indicated when the statistical significance reached a level of $p < .05$ or better.

[29] For core measures in place only since 2012, most of the DFC coalitions in the all DFC ever funded are also in the FY 2014 only sample. For example, to date 311 DFC coalitions ever funded have two data points reported on past 30-day prevalence of use of prescription drugs for middle school youth. Of these 311, 274 (88%) were also in the FY 2014 only sample. In comparison, only 491 of the 1120 DFC coalitions who have reported past 30-day prevalence of alcohol use among middle school youth (44%) were in the FY 2014 only sample.

[30] In the dot plots, first report is indicated by the gray marker while most recent report is indicated by the teal green marker. Change in the desired direction is apparent when the teal marker (most recent report) is to the right of the gray marker (first report).

[31] Significant differences at the $p < .05$ level are indicated with an asterisk.

Figure 6. Past 30-Day Prevalence of Non-Use from First to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates $p < .05$ (significant difference); numbers are percentages
Source: Progress Report, 2002-2016 core measures data

Second, while most youth did not report past 30-day use of alcohol, alcohol was the substance with the lowest past 30-day prevalence of non-use among middle school and high school youth, at first and most recent report, both for all DFC coalitions ever funded and FY 2014 DFC coalitions only. That is, alcohol was the substance youth were most likely to report having used in the past 30-days. Among high school youth, nearly two-thirds reported they did not use alcohol at first report and this increased to just under three-fourths by most recent report. For example, across all DFC coalitions funded since inception, 70.7% of high school youth reported past 30-day alcohol non-use at most recent report. In comparison, over 80% of high school youth reported not using marijuana or tobacco and over 90% reported they had not used prescription drugs not prescribed to them. In both samples, 90% or more of middle school youth reported they had not used each of the given substances at most recent report, including alcohol although alcohol again had the lowest prevalence of non-use. The relatively high rates of past 30-day prevalence of alcohol use (e.g., within the FY 2014 sample at most recent report 26% of high school youth reported past 30-day use) suggests the need for ongoing prevention efforts such as those provided by DFC coalitions.

Third, reported past 30-day prevalence of illicit use of prescription drugs was lower than for all other substances. Fewer than 3% of middle school youth and only 5-7% of high school youth report using prescription drugs not prescribed to them in the past 30-days. While prevalence of non-use was high, even at first report, youth in communities targeted by DFC coalitions significantly increased in prevalence of illicit prescription drug non-use from first to most recent report.

Finally, the percentage of high school youth reporting past 30-day non-use of marijuana was lower than the percentage of youth reporting past 30-day non-use of tobacco, in most cases. That is, more high school youth reported past 30-day use of marijuana than of tobacco. The exception to this was for first report across all DFC recipients since inception in which prevalence of non-use was similar for tobacco and marijuana (81.9% and 81.8%, respectively). For the FY 2014 DFC coalitions, middle school youth also reported slightly lower prevalence of non-use of marijuana (96.1%) than of tobacco (97.0%) at most recent report.

Percentage Change In Prevalence of Past 30-Day Use

To put these findings in perspective, the amount of change in past 30-day prevalence of use (from first to most recent report) can also be considered as a percentage change relative to the first report. That is, given that past 30-day prevalence of non-use has increased, what was the percentage decrease in past 30-day prevalence of use? Figure 7 (all DFC grant award recipients ever funded) and Figure 8 (FY 2014 grant award recipients) present

percentage change data (see Table D.1, Appendix D for the underlying data used to calculate percentage change).[32]

Figure 7: Percentage Change in Past 30-Day Alcohol, Tobacco, Marijuana, and (Illicit) Prescription Drug Prevalence of Use: Long-Term Change Among All DFC Grant Award Recipients Since Grant Inception

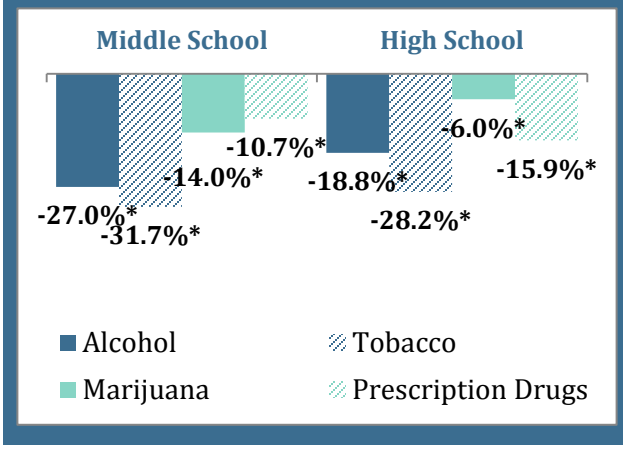
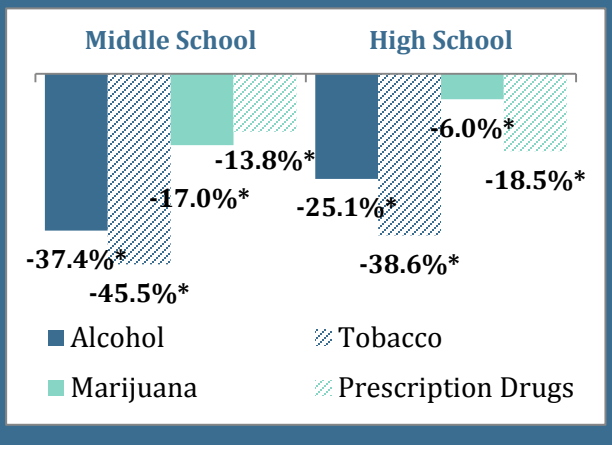


Figure 8: Percentage Change in Past 30-Day Alcohol, Tobacco, Marijuana, and (Illicit) Prescription Drug Prevalence of Use: Long-Term Change Among FY 2014 DFC Grant Award Recipients



Notes: * p<.05; Percentage change outcomes represent weighted averages for each DFC grantee based on the total number of youth used in the percentage point change calculation (i.e., adding number of youth surveyed at first observation to number surveyed at most recent observation). Change scores were rounded as presented in Table 8 for these calculations.

Source: Progress Report, 2002-2016 core measures data

As shown in Figure 7, prevalence of alcohol use declined by 27%, prevalence of tobacco use declined by 32%, prevalence of marijuana use declined by 14%, and prevalence of (illicit) prescription drug use declined by 11% from the first to the most recent data reports among middle school youth across all DFC coalitions ever funded. As a reminder, while the decline in middle school youth prescription drug use was significant, almost all middle school youth (97%) report they did not use prescription drugs not prescribed to them in the past 30-days. This contributes to the relatively small percentage change. High school prevalence of use for alcohol declined by 19%, for tobacco declined by 28%, for marijuana declined by 6%, and for (illicit) prescription drug use declined by 16%. As reported, all of the reductions in past 30-day prevalence of use were significant.

Percentage decreases in past 30-day prevalence of use among the FY 2014 grant award recipients (see Figure 8) followed similar patterns to those for all DFC grant awards to date (see Figure 7). In this sample, the percentage decreases were again largest for reports of tobacco use for both middle school (46%) and high school (39%) youth.

[32] Percentage change (i.e., relative change) demonstrates how much change was experienced relative to the baseline. It is calculated as the percentage point change (most recent report minus first report) divided by first report percentage.

Alcohol Core Measures Findings

Figure 9 provides the alcohol core measures data findings (see also Appendix D). For alcohol, both perception of risk and parental disapproval core measures were redefined in 2012 and peer disapproval was also first introduced as a core measure. Therefore, this change data has been collected only from 2012-2016 and a much smaller number of DFC coalitions have change data for these three alcohol core measures as compared to past 30-day prevalence of non-use (collected from 2002 to 2016).

For all DFC grant award recipients since inception and for the FY 2014 DFC coalitions, most of the alcohol core measures differences between first and most recent report were significant increases. The one exception in both samples was for middle school youth's perception of parental disapproval which was high at both time points (~94%) and did not change significantly.

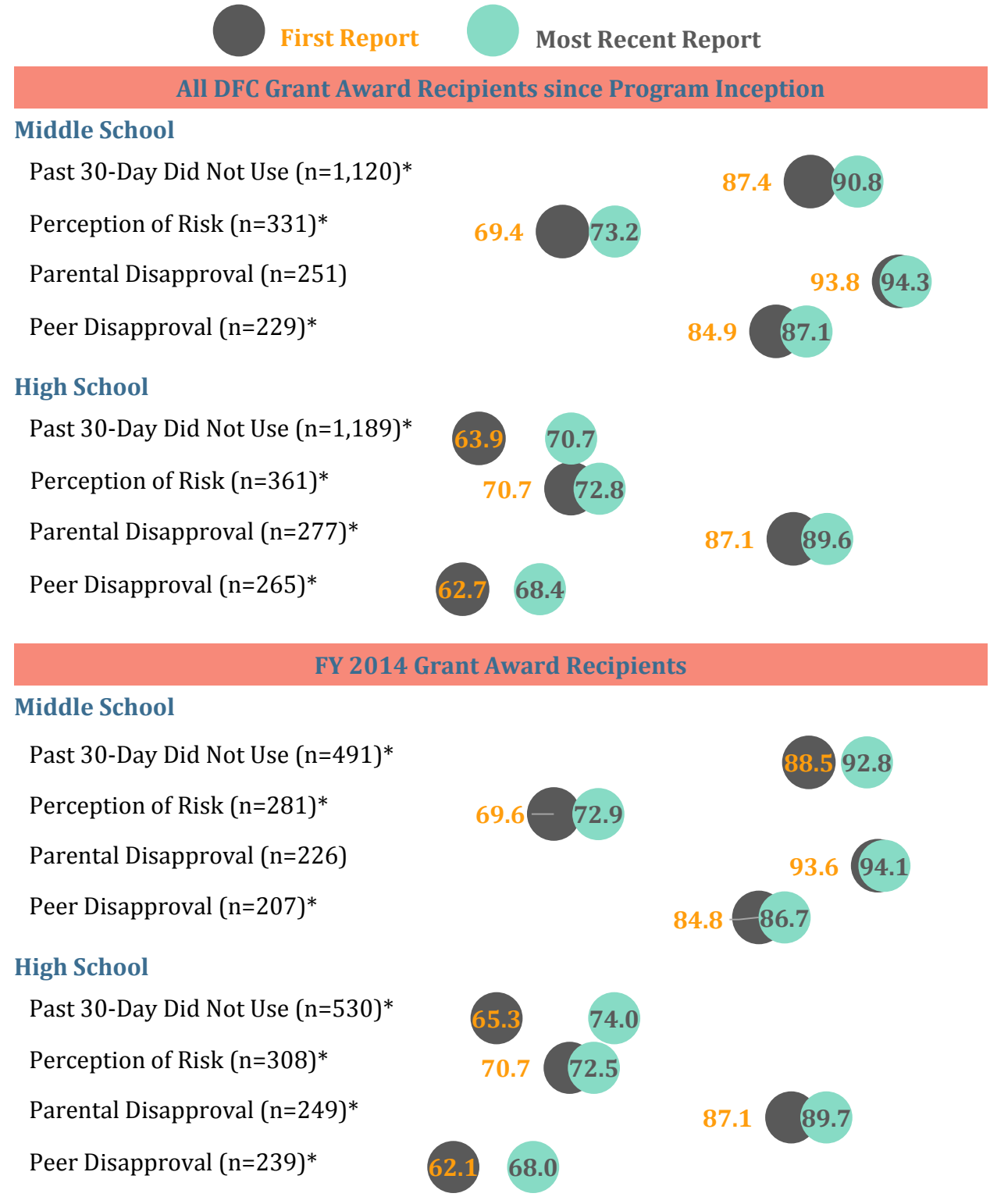
Alcohol Perception of Risk

Beginning in 2012, perception of risk of alcohol use was defined as associated with binge alcohol use (five or more drinks of an alcoholic beverage [beer, wine, liquor] once or twice a week). As can be seen (Figure 9; see also Table D.3, Appendix D), among middle school youth, perception of risk increased from first to most recent report for both all DFC coalitions since inception and FY 2014 DFC coalitions (3.8 and 3.3 percentage points, respectively). Perception of risk of alcohol use (binge drinking) also increased significantly from first to most recent report among high school youth within all DFC coalitions and within the FY 2014 DFC coalitions (2.1 and 1.8 percentage points, respectively). At just under three-fourths, percentages of middle school youth who perceived risk associated with this type of alcohol use were similar to percentages of high school youth, suggesting that DFC coalitions may need to identify strategies for helping middle school youth to understand risk associated with binge drinking. The relatively low perception of risk among middle school youth of alcohol use may be one potential explanation for the lower percentage of high school youth reporting past 30-day alcohol non-use. That is, the ~30% of middle school youth who do not perceive risk in drinking alcohol (binge use) may be more likely to begin drinking alcohol, including binge use, once in high school.

Alcohol Perception of Parent and Peer Disapproval

Perception of parental disapproval of alcohol use for middle school youth in both samples of DFC award recipients was high at both first and most recent report (~94%) (see Figure 9 and Table D.4, Appendix D). High school youth's perception of parent disapproval of alcohol use at first report were also high (~87%), and increased significantly by similar amounts in both samples. Perception of peer disapproval of alcohol use increased significantly for both samples for both middle school and high school youth. Within middle school youth the increase was from 85% to 87% across the two samples (increases of 2.2

Figure 9. Alcohol Core Measures: Percentage Point Change from First to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates p < .05 (significant difference); numbers are percentages
Source: Progress Report, 2002-2016 core measures data

and 1.9 percentage points, respectively). Fewer high school youth than middle school youth perceived peer disapproval associated with alcohol use. At first report, on average just under two thirds of high school youth in both all DFC ever funded and the FY 2014 only DFC coalitions perceived disapproval although this increased significantly by most recent report (increases of 5.7 and 5.9 percentage points, respectively). For high school youth, the percentages perceiving disapproval were similar to those reporting non-use. This suggests that it is possible that high school youth who are not using alcohol perceive disapproval, although it is not possible to connect individual youth's responses on these items at the national level.

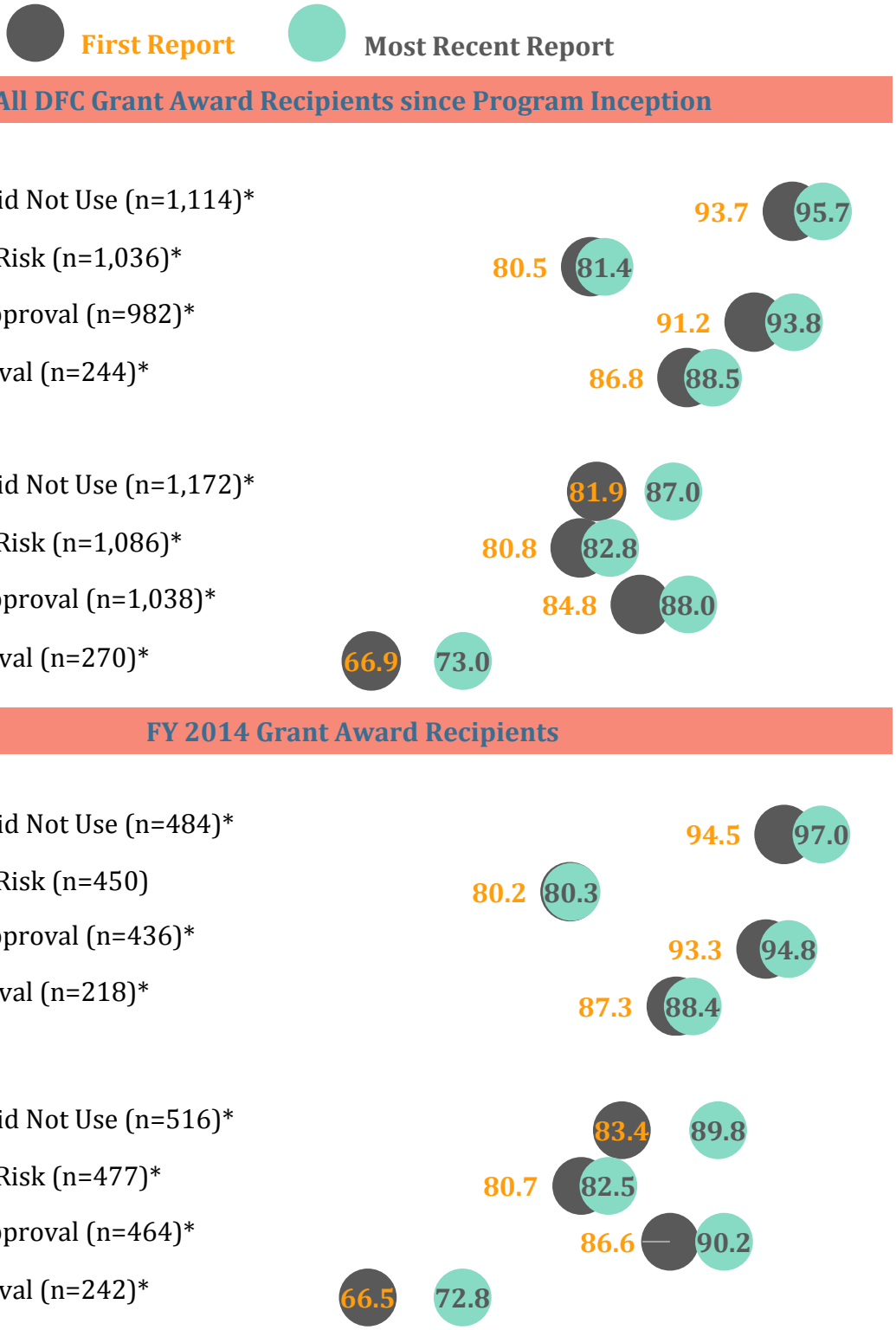
Within both middle school and high school youth, perceived disapproval of alcohol use was lower relative to peers as compared to parents (see Figure 9 and Tables D.4 and D.5, Appendix D). Within middle school youth, the difference was approximately 7-10 percentage points lower depending on time of report and sample. By high school, only about two-thirds of high school youth perceived peers as disapproving of alcohol use while over 85% perceived parents as disapproving at any given time point, a difference of over 20 percentage points.

Tobacco Core Measures Findings

Figure 10 provides the tobacco core measures data findings. The past 30-day prevalence of non-use of tobacco increased significantly for both age groups and both samples (see also Table D.2, Appendix D). In general, percentages of youth reporting not using tobacco, perceiving risk in tobacco use and perceiving parental and peer disapproval was high (greater than or equal to 80%) at both first and most recent report for both age groups and for both all DFC and FY 2014 only grant award recipients. The notable exception to this was high school youth's perceptions of peer disapproval which ranged from 66-73% (see also Table D.5, Appendix D). This finding suggests that while high school youth do not seem to perceive risk of tobacco use differently from middle school youth, they do seem to view tobacco use as less likely to meet with peer disapproval.

Perceived risk of tobacco use was high and increased significantly in all but one subgroup (see also Table D.3, Appendix D). Middle school youth's perception of risk in the FY 2014 sample did not increase significantly from first to most recent report (80.2% and 80.3%, respectively). Perception of both parent and peer disapproval (tobacco use wrong or very wrong) increased significantly for both middle school and high school youth in both samples.

Figure 10. Tobacco Core Measures: Change from First to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates p < .05 (significant difference)**:** numbers are percentages
Source: Progress Report, 2002-2016 core measures data

Marijuana Core Measures Findings

Figure 11 provides the marijuana core measures data findings (see also Appendix D). The majority of both middle school and high school youth reported not using marijuana in the past 30-days within both samples, and past 30-day prevalence of non-use increased significantly from first to most recent report (see also Table D.2, Appendix D). The percentages of middle school youth who perceived risk, parent disapproval and peer disapproval was also generally high at both first and most recent report (71% or more perceived risk, 92% or more perceived parental disapproval, and 85% or more perceived peer disapproval). By high school, smaller percentages of youth than in middle school perceived risk, parental disapproval, and peer disapproval associated with marijuana use (53-56% perceived risk, 86-87% perceived parental disapproval, and 55-57% perceived peer disapproval).

Marijuana Perception of Risk

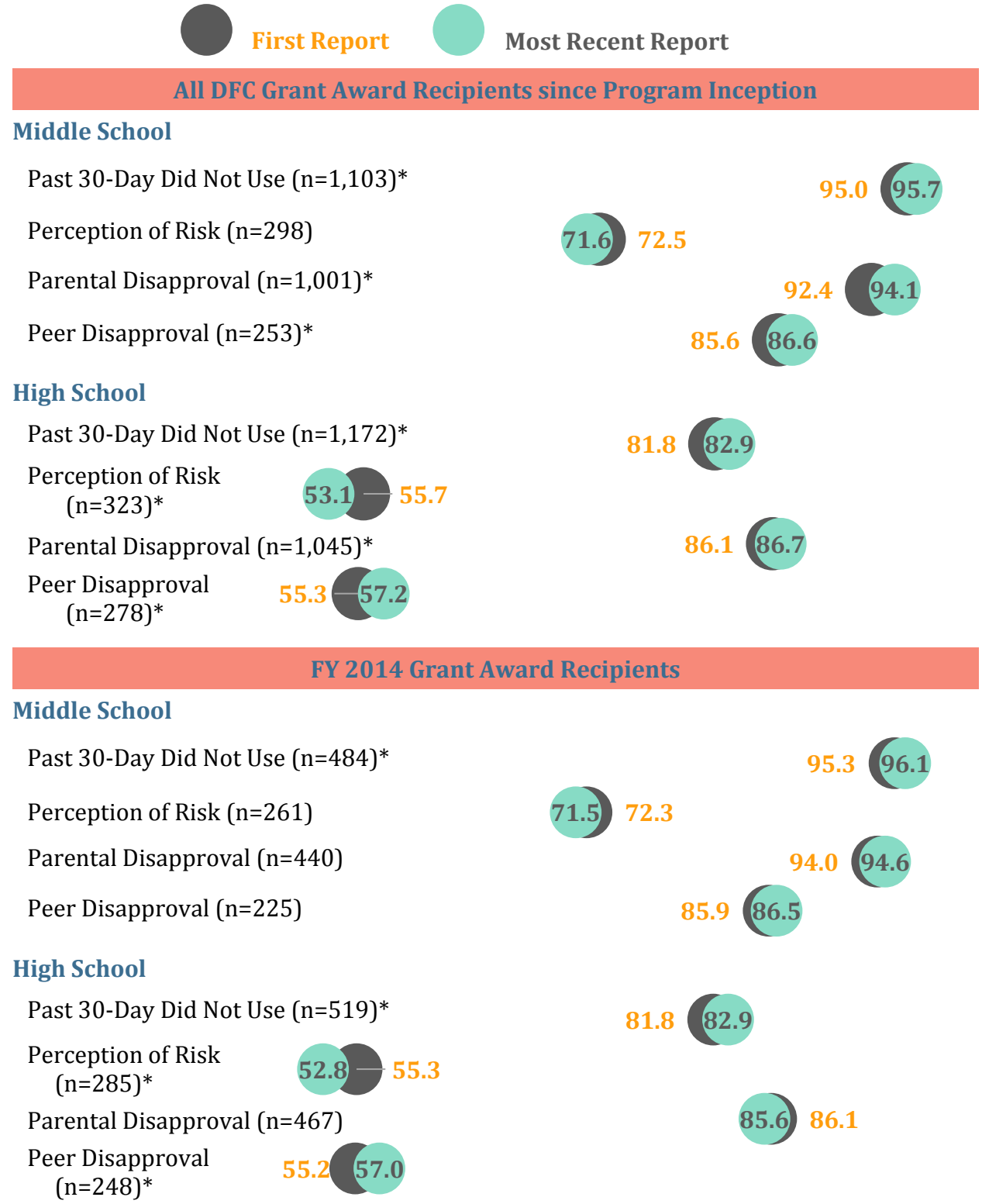
As noted, the measure for perception of risk as currently worded (smoke marijuana once or twice a week) was introduced in 2012 (see Table D.3, Appendix D). From 261 to 323 coalitions have collected this data at two time points to date. The majority of all DFC coalitions included in the marijuana perception of risk analyses are also FY 2014 DFC coalitions (i.e., 87% for the middle school samples, 88% for the high school samples). That is, the analyses for the two samples are very similar given the amount of overlap between the two samples.

Among middle school youth, perceived risk of marijuana use did not change significantly from first to most recent report within either sample. For high school youth, perceived risk of marijuana use decreased significantly from first to most recent report within both samples (decreases of 2.6 and 2.5 percentage points). That is, significantly fewer youth perceived risk associated with smoking marijuana once or twice a week at most recent report, an undesirable outcome.

Marijuana Perception of Parental and Peer Disapproval

Both middle school and high school youth reported relatively high levels of perceived parental disapproval of marijuana use (greater than 92% of middle school youth and 85% of high school youth, see Table D.4, Appendix D). For middle school youth, there was a significant increase in perceived parental disapproval across all DFC coalitions ever funded (1.7 percentage points) but not for the FY 2014 sample. Perceived parental disapproval also increased significantly among high school youth across all DFC coalitions ever funded from first to most recent report (86.1% and 86.7%, respectively) but was unchanged for high school youth within the FY 2014 sample. Within high school youth, the percentage reporting perceived parent disapproval of marijuana use at most recent report was high

Figure 11. Marijuana Core Measures: Change from First to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates $p < .05$ (significant difference)**:** numbers are percentages
Source: Progress Report, 2002-2016 core measures data

(over 85%) but was slightly lower than for any other substance, including alcohol (over 89% perceived parental disapproval of alcohol use).

Perception of peer disapproval of marijuana use generally increased significantly from first to most recent report (see Figure 11 and Table D.5, Appendix D). There was a significant increase in middle school youth's perceptions of peer disapproval within all DFC grant award recipients from first to most recent report (85.6% and 86.6%, respectively). For high school youth, perceptions of peer disapproval increased significantly within both all DFC coalitions ever funded and the FY 2014 sample (1.9 and 1.8 percentage points, respectively). The exception to this was for middle school youth in the FY 2014 sample which was unchanged. Additionally, while perceived peer disapproval of marijuana use increased significantly, it was still under 58% in high school youth at most recent report. The percentage of youth perceiving peer disapproval was generally lower for marijuana than for any other substance, particularly among high school youth (see Table D.5, Appendix D). For middle school youth, perceptions of peer disapproval of marijuana use were similar to perceptions of peer disapproval of alcohol use, both of which were lower than for the remaining core measure substances (tobacco and prescription drug use).

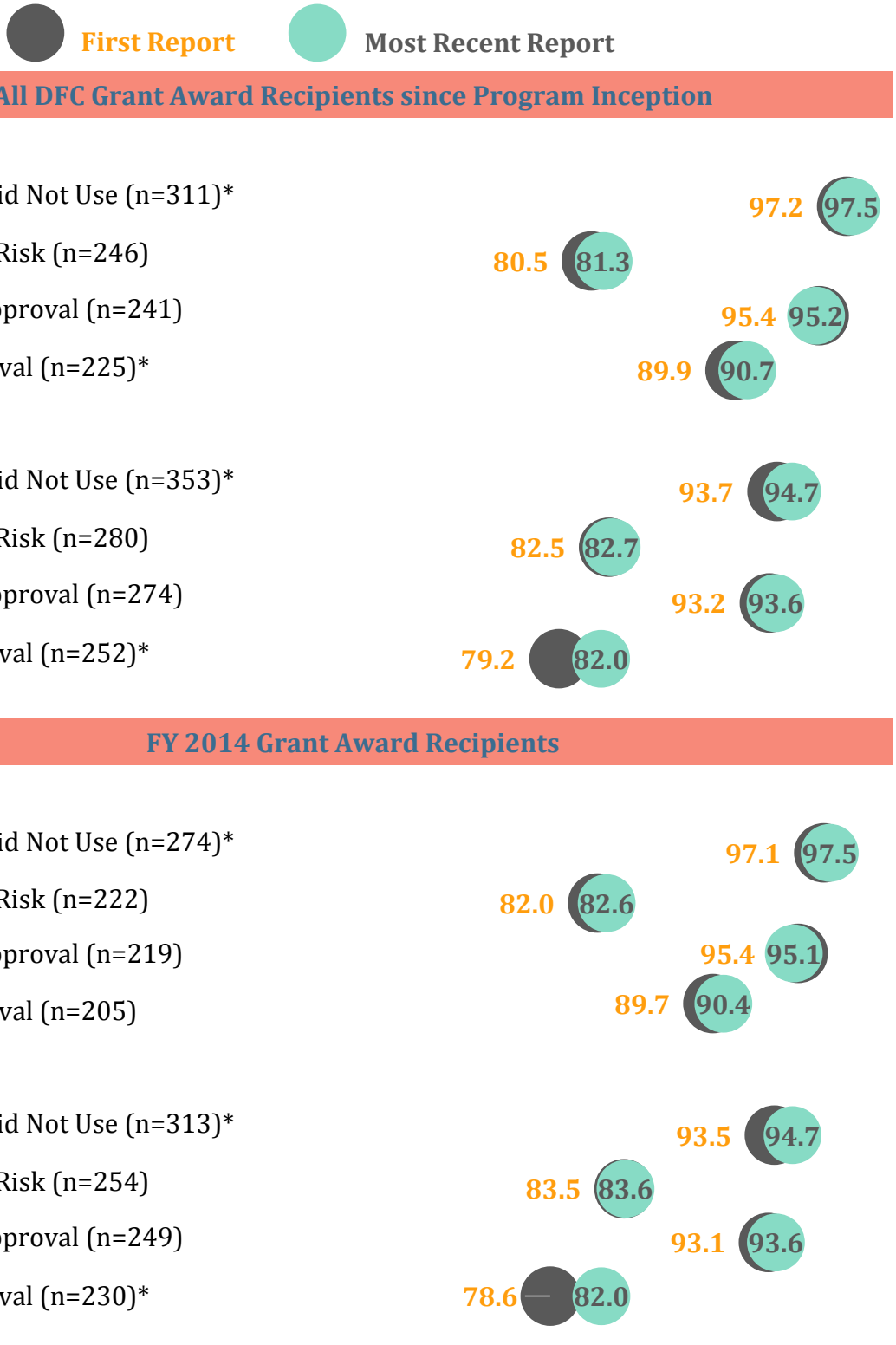
Prescription Drugs (Illicit Use) Core Measures Findings

Figure 12 provides the illicit use of prescription drugs (use of prescription drugs not prescribed to you) core measures data findings (see also Appendix D). Illicit use of prescription drugs was introduced as a core measure substance in 2012. Therefore the data for all core measures for this substance reflects a generally smaller sample of DFC coalitions than for other core measure substances (and the two samples include many of the same coalitions). Over 97% of middle school and 93% of high school youth report that they have not illicitly used prescription drugs in the past 30-days, a high percentage that increased significantly from first to most recent report for both age groups in both samples (see Figure 12 and Table D.2, Appendix D).

Perception of risk of illicit prescription drug use was generally high (greater than 80%), but did not increase significantly from first to most recent report (see Figure 12 and Table B.3, Appendix D). This was true for both middle school and high school youth and for both samples. Perceived risk of illicit use of prescription drugs was very similar to perceived risk of tobacco use (80-83%), and was higher than for both alcohol (69-73%) and marijuana use (52-73%; see Table D.3, Appendix D).

Youth perceptions of parental disapproval for both age groups and both samples was high (over 95% in middle school youth and over 93% in high school youth) and was unchanged from first to most recent report (see Table D.4, Appendix D). Peer disapproval increased significantly for both age groups within all DFC coalitions and within high school youth

Figure 12. Prescription Drugs (Illicit Use) Core Measures: Change from First to Most Recent Report by School Level and DFC Grant Award Recipient Group



Note: * indicates p < .05 (significant difference); numbers are percentages
Source: Progress Report, 2002-2016 core measures data

within the FY 2014 sample, but was unchanged for middle school youth in the FY 2014 sample (see Figure 12 and Table D.5, Appendix D). For both middle school and high school youth, perceived peer disapproval was higher for illicit prescription drug use than for any other substance. For high school youth, the same was true for parental disapproval while middle school youth perception of parental disapproval was similar across substances.

Comparison to National Data

Results on changes in past 30-day prevalence of use within DFC coalitions were also compared to findings from a nationally representative sample of high school students taking the Youth Risk Behavior Survey (YRBS).[33] Most DFC coalitions indicate that their data are collected using surveys provided to schools. Given that some of the DFC grantees' data are included in the national YRBS data as some grantees report using the YRBS to track local trends; these comparisons are conservative estimates of the difference DFC is making in communities.

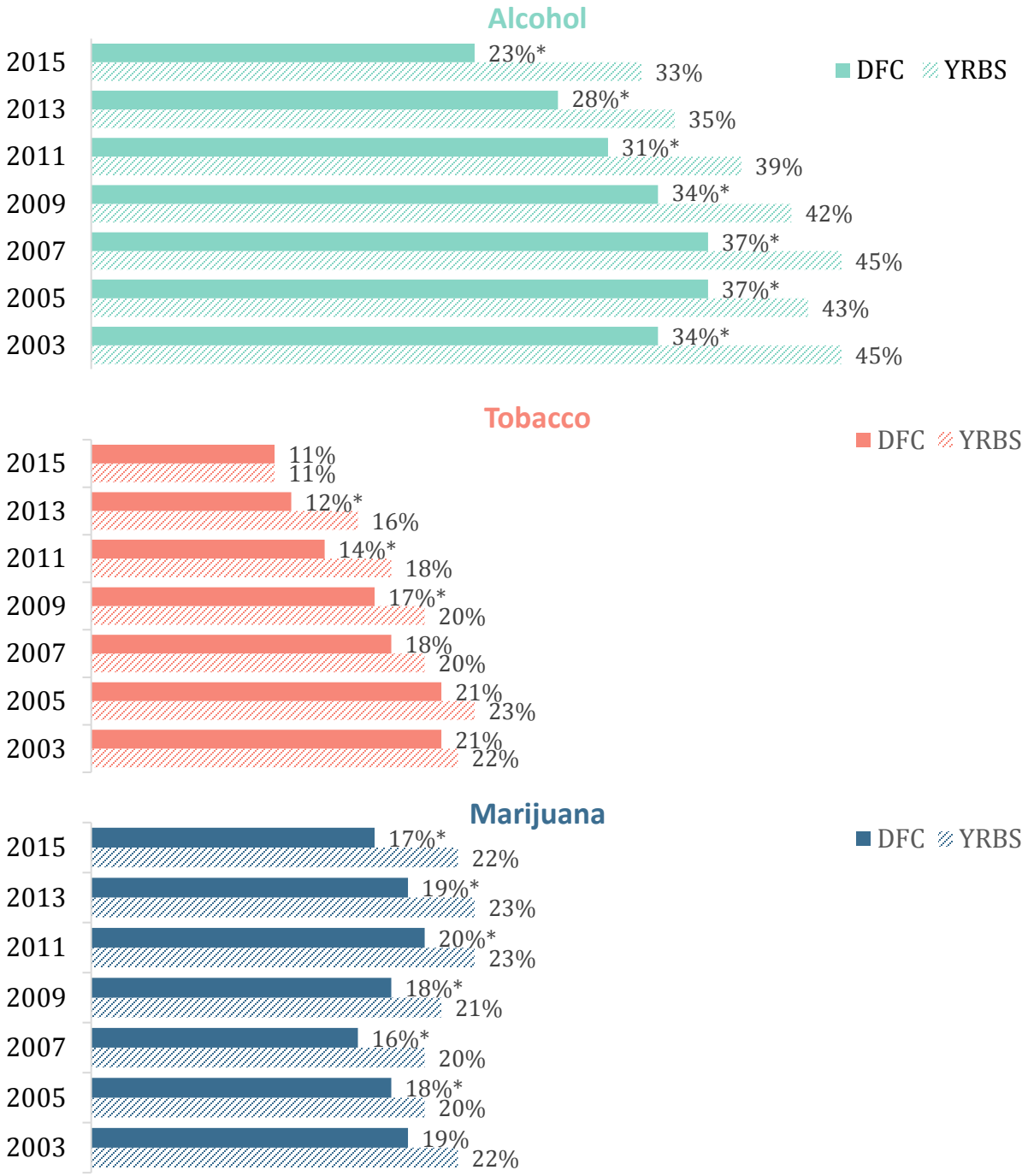
As shown in Figure 13, prevalence rates of past 30-day alcohol use among high school students were significantly lower in communities with a DFC grantee than in areas sampled by the YRBS in all seven years compared (i.e., 2003, 2005, 2007, 2009, 2011, 2013, and 2015). In 2015, the difference between the DFC and YRBS samples on the mean past 30-day prevalence of alcohol use was ten percentage points (23% and 33%, respectively).

For high school tobacco use, there was no significant difference between the YRBS and DFC samples in 2015 (11% reported past 30-day use in each sample). Fewer youth in DFC communities than in the YRBS national sample reported tobacco use in 2009, 2011, and 2013, while in all other years there was no difference. In general, tobacco use trended towards a decrease from 2005 to 2015, but the DFC coalitions dropped more quickly and had less change between 2013 and 2015.

Prevalence rates for marijuana use were significantly lower in DFC communities than in the YRBS national sample in all years except 2003. In 2015, 17% of high school youth reported past 30-day marijuana use as compared to 22% in the YRBS national sample. In general, high school youth in the national sample have remained relatively the same from 2011 to 2015 while high school youth in the DFC sample dropped from 20% in 2011 to 17% in 2015 reporting past 30-day use.

[33] Centers for Disease Control and Prevention. 2015 Youth Risk Behavior Survey Data. Available at: https://www.cdc.gov/healthyyouth/data/yrbs/data.htm. Accessed on April 6 2017. Center for Disease Control YRBS data corresponding to DFC data are available only for high school students on the measures of 30-day use, and only for alcohol, tobacco and marijuana. YRBS is a nationally representative survey which includes sample respondents drawn from both DFC and non-DFC communities. YRBS data are collected in odd years and comparisons here are for the years from 2003 to 2015. DFC results are based on the coalitions that reported collecting core measures data in a given year. For more information on YRBS data please see https://www.cdc.gov/healthyYouth/data/yrbs/index.htm. Comparisons examine confidence intervals (95%) for overlap between the two samples.

Figure 13. Comparison of DFC and National (YRBS) Reports of Past 30-Day Alcohol, Tobacco, and Marijuana Prevalence of Use Among High School Students



Note: Comparisons are between YRBS and DFC data examining confidence intervals for overlap between the two samples; * indicates $p < .05$ (significant difference)**;** numbers are percentages of youth reporting past 30-day use

Source: DFC Progress Report, 2003-2015 core measures data; Centers for Disease Control and Prevention. 2015 Youth Risk Behavior Survey Data downloaded from https://www.cdc.gov/healthyyouth/data/yrbs/data.htm on April 6 2017.

Community Assets Findings

Every August, DFC grantees complete the Coalition Classification Tool (CCT), a survey that asks coalition members to provide information on coalition structure, performance, objectives, and local characteristics. In August 2016, 605 FY 2015 DFC coalitions completed the CCT. One section of the CCT asks grantees to identify which of 40 specific community assets commonly associated with youth substance use reduction and prevention were in place in their coalitions before they received the DFC grant, those that were in place as a result of receiving the grant, and those not yet in place in the DFC community to date.[34] Examples from the list of 40 potential community assets that DFC grantees may put into place include billboards warning against the use of alcohol, tobacco, or other drugs, media literacy training, shoulder tap operations, and party patrols. While all these assets may enhance the coalition's capacity to prevent or reduce youth substance use, those that were implemented as a result of DFC coalition efforts provide an additional source of information about the local impact of the grant. That is, these assets may still not have been in place in the community if not for the DFC grant award. Table 9 presents the top five community assets put into place as a result of the DFC grant by FY 2015 DFC grantees as reported in August 2016. That is, of the 40 community assets listed, these five assets had the highest percentage of grantees who were able to put the asset in place in their community as a result of the DFC grant.[35]

Coalition Voices: Social Norms Campaigns

"We are currently focusing on youth led social norms campaigns and safe disposal systems for prescriptions drugs. To date, we have seen belief and behavior changes in the first school to implement our strategy."

"We have successfully implemented a social norming campaign around underage drinking at home. Five billboards are displayed throughout the county and banners have been delivered to schools. At the athletic events this school year PSA's around drug use and prevention will be read throughout the games."

Town hall meetings were the most common asset put into place by DFC grantees as a result of the grant (71%). Only 10% of DFC coalitions reported still not having town hall meetings as a community asset. DFC coalitions also reported that they were able to create culturally competent materials to educate the community about substance use as a result of the grant (69%). Most (93%) DFC coalitions also offered prescription drug disposal programs. While 26% of the responding DFC coalitions already had a prescription drug disposal program in place prior to receiving the grant, about two-thirds (67%) of coalitions initiated this activity only after receiving their DFC grant. Other community assets that were put into

[34] DFC grantees actually report on which of the community assets have been put into place in their community in the past year as a result of being a DFC coalition as well as indicating those ever put into place as part of the DFC grant. For the purposes of this report, these two categories were combined.

[35] These were the only five assets where more than 50% of DFC coalitions put the asset into place after DFC grant award.

Table 9: Most Frequently Implemented Community Assets

Community Asset	n of DFC Coalitions Responding to item	% With Asset Put into Place as a Result of DFC Coalition Grant Award	% With Asset in Place Before DFC Grant	% With Asset Not in Place in Community
Town hall meetings on substance problems within the community	605	70.8%	19.0%	10.2%
Culturally competent materials that educate the public about issues related to substance use	605	69.1%	19.7%	11.2%
Social norms campaigns	605	68.8%	14.4%	16.8%
Prescription drug disposal programs	605	66.9%	26.9%	6.2%
Youth substance use warning posters	605	52.4%	24.6%	23.0%

Notes: The number of DFC grantees reporting CCT data in August 2016 was 605. For a small number of items, only 604 DFC coalitions responded
Source: Coalition Classification Tool Data, August 2016

place by a high percentages of DFC grantees as a result of receiving a DFC grant included social norms campaigns (69%) and youth substance use warning posters (52%).

Social norms campaigns stand out as a top five asset added by DFC grantees given the reported increases in peer disapproval measures in DFC grantees communities. In all, about 83% of DFC grantees have a social norm campaign in their community, but most (69%) of these DFC grantees put a social norms campaign into place only after receiving DFC funding as compared to the 14% already engaging in a social norms campaign prior to receiving funding. Social norms campaigns generally focus on giving youth factual and motivational information about the positive behaviors engaged in by peers with the intention of helping youth recognize that most youth are not engaging in negative behaviors. As noted in the core measures findings, continued efforts on social campaigns may help to counter beliefs that might otherwise contribute to possible increases in past 30-day prevalence of use.

Conclusions

This report provides a summary of findings for the DFC program through the August 2016 progress reporting window. Following is an overview of key takeaways from this report.

Nearly half of the US population has lived in a community with a DFC coalition since 2005 and 1-in-5 Americans lived in a community with a DFC coalition in 2016.

Since inception, a wide range of people and communities have been exposed to the federally funded DFC Support Program. Based on DFC coalitions reports of zip codes served as compared to census data, DFC grant award recipients have targeted areas that covered 48% of the US population between 2005 and 2017. In 2016 alone, the 675 DFC coalitions funded in FY 2015 targeted services to communities with 61.7 million people, 20% of the population of the United States. This includes 2.5 million middle school and 3.5 million high school aged youth.

Youth in DFC communities reported increased past 30-day prevalence of non-use (decreased use) of alcohol, tobacco, marijuana and (illicit) prescription drugs.

DFC coalitions made significant progress towards achieving the goal of preventing and reducing youth substance use. The majority of both middle school and high school youth in communities with a DFC coalition report that they have not used each of the core substances (alcohol, tobacco, marijuana, and illicit use of prescription drugs) in the past 30-days, and prevalence of non-use increased significantly from first to most recent report. This was true for youth based on data from all DFC coalition since inception and on data from only FY 2014 DFC coalitions. Among middle school youth, prevalence of past 30-day non-use at most recent report within the FY 2014 DFC coalitions averaged over 92% for each of the substances (a significant increase of 0.4 to 4.3 percentage points from first to most recent report). Among high school youth at most recent report in the FY 2014 sample, there was similarly high prevalence of non-use for tobacco (89.8%) and of prescription drugs (illicit use; 94.7%); increases of 6.4 and 1.2 percentage points from first to most report, respectively.

Fewer high school youth in the FY 2014 sample reported past 30-day non-use of alcohol (74.0%) and marijuana (82.9%) at most recent report as compared to tobacco and (illicit) prescription drug non-use, although these were significant increases from first report (1.2 and 8.7 percentage points, respectively). For both middle school and high school youth, alcohol was the substance with the lowest reported past 30-day prevalence of non-use, while prescription drugs had the highest reported non-use.

Social norms campaigns are one activity utilized by the majority (83%) of DFC coalitions to prevent use. These campaigns focus on giving youth factual and motivational information about the positive behaviors engaged in by peers with the intention of helping youth recognize that most youth are not engaging in negative behaviors. The finding that the majority of youth are not engaging in substance use, with respect to each core measure substance, may be useful in supporting DFC coalitions in using social norms campaigns.

While increased non-use is promising, the prevalence of youth who report past 30-day use, including just over 1-in-4 (26%) high school youth who reported past 30-day use of alcohol and just over 1-in-6 (17.1%) high school youth who reported past 30-day use of marijuana at most recent report in the FY 2014 sample, suggests the need for programs like DFC that support communities in engaging in ongoing strategies to address prevention.

Youth in DFC communities generally reported high and/or increased perceptions of parental and peer disapproval.

Among middle school youth in communities served by DFC coalitions, 90% or more in both samples (all DFC and FY 2014 only) perceived parental disapproval across all substances (alcohol, tobacco, marijuana, illicit use of prescription drugs) at both first and most recent report, with generally no significant change. The exceptions to this were for perceived parental disapproval for tobacco use which increased significantly in both samples and for marijuana use which increased significantly for all DFC coalitions funded (but not for the FY 2014 only sample). For middle school youth in all DFC ever funded, there were significant increases in perceived peer disapproval across all four substances. However, middle school youth in the FY 2014 sample had significantly increased perceptions of peer disapproval for alcohol and tobacco but no change in perceptions of peer disapproval of marijuana use and illicit use of prescription drugs.

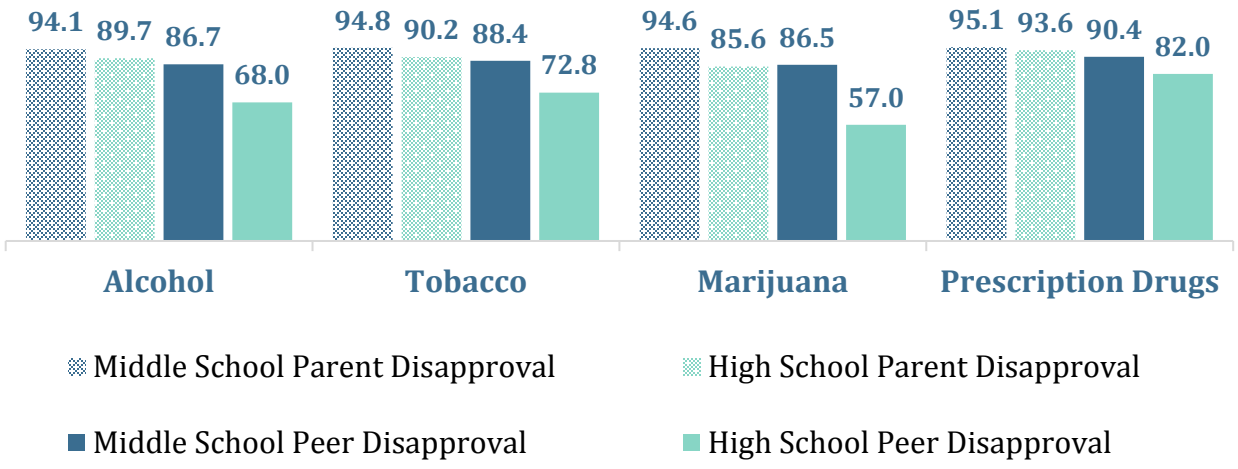
For high school youth in both samples, there were significant increases in perceived peer disapproval for all substances while the findings for parental disapproval were again somewhat more complex. Within all DFC coalitions ever funded, there were significant increases in perceived parental disapproval with the exception of parental disapproval of illicit prescription drug use, which was unchanged. In the FY 2014 sample, perception of parental disapproval increased significantly for alcohol and tobacco but was unchanged for both marijuana and illicit prescription drug use.

While generally high in both age groups, perceived peer disapproval for substance use was lower among high school youth than middle school youth for all substances. Using the FY 2014 sample at most recent report as an example (see Figure 14; see also Table D.5, Appendix D), high school youth's perceptions of peer disapproval as compared to middle school youth's perceptions of marijuana use was 30 percentage points lower and for alcohol use it was 20 percentage points lower. In comparison, high school youth's

perceptions of parent disapproval were only slightly lower than middle school youth's perceptions, across substances (see Figure 14 and Table D.4, Appendix D).

These findings suggest the need for DFC coalitions to continue efforts to help youth understand peer disapproval. Tobacco data for the all DFC since inception sample at most recent report provides a good example of this. While only 4% of middle school youth and 13% of high school youth reported past 30-day tobacco use, 12% of middle school youth and 27% of high school youth perceived that peers would not disapprove of such use. Similarly, far fewer youth report past 30-day use of marijuana than report perceiving peers would disapprove of such use. Social norms campaigns may be one strategy to inform high school youth about the extent to which peers may disapprove of use given their own unwillingness to use a given substance.

Figure 14. Perceptions of Parental Disapproval Across the Two Age Groups and Middle School Youth's Perceptions of Peer Disapproval were Higher Than High School Youth's Perceptions of Peer Disapproval, FY 2014 Most Recent Report



Note: Numbers indicate percentages perceiving disapproval (wrong or very wrong). Similar patterns were seen for all DFC coalitions ever funded and for first report

Source: Progress Report, 2002-2016 core measures data

As can be seen in Figure 14, perceived peer disapproval of marijuana use among high school youth was lower for marijuana than for any other substance at most recent report. This finding in conjunction with findings on perception of risk presented next suggest the need to further inform middle and high school youth about potential consequences of marijuana use, especially marijuana use at these ages.

Perception of risk data suggest that DFC coalitions may need to engage in additional activities to help youth understand risk associated with use, especially risk associated with alcohol and marijuana use.

Perceived risk of tobacco use was generally high (80% to 83% across grade levels and samples) and either increased significantly from first to most recent report or remained unchanged. Similarly, across grade levels and samples most youth (81% to 83%) perceived risk associated with illicit use of prescription drugs, although with no significant change from first to most recent report.

Findings for perception of risk of alcohol (binge use) suggest several needs. Fewer than 75% of middle school and high school youth (69% - 73%) perceived risk associated with binge alcohol use, although perceived risk did increase significantly in both age groups in both samples. That is, middle school youth and high school youth were very similar in their perceptions of risk of alcohol use. One explanation for why more youth may not perceive risk may be that youth did not understand what binge drinking is and why it may be particularly harmful. That is, they may not understand that 5 or more drinks at a single time is a high amount of alcohol consumption. DFC coalitions may want to engage in activities that explain specific risks associated with binge alcohol use to youth in both age groups. Given that alcohol is the most commonly used substance by both middle and high school youth, increased understanding of associated risks may also contribute to decreased use over time. Again, these efforts likely need to begin in middle school as reported past 30-day prevalence of alcohol use increases from middle school to high school (from ~10% to ~30%). DFC national evaluation data do not separate binge alcohol use from taking a single sip of alcohol so it is unknown the extent to which youth are engaging in higher risk alcohol use behaviors.

High school youth in both samples reported perceptions of risk of marijuana use that decreased significantly from first to most recent report, while middle school youth's perceptions were unchanged. That is, perceptions of risk of marijuana use among youth, even in DFC communities is changing in the wrong direction. In addition, while just under 75% of middle school youth perceived risk in marijuana use, by high school at most recent report, only 52-53% perceived moderate or great risk associated with marijuana use. In fact, perceived risk of marijuana use at most recent report was lower than for any other substance, including alcohol. These findings suggest the need, beginning in middle school, for strategies to help youth understand risk associated with marijuana use. One reason for concern is that this decreased perception or risk may eventually be associated with increased past 30-day prevalence of use. DFC coalitions may need to improve or increase efforts to develop appropriate materials and training strategies to help youth better understand risk associated with marijuana use in order to better inform youth. As can be

seen in Figure 14 (see also Tables D.4 and D5, Appendix D), high school youth's perceptions of both peer and parental disapproval were lower for marijuana use than for any other substance within the FY 2014 sample at most recent report further suggesting the need for additional focus by DFC coalitions on this substance.

DFC coalitions successfully mobilized communities and engaged in a comprehensive range of strategies in developing local solutions to a range of local problems, including addressing opioids, in line with the goals of DFC.

On average, DFC coalitions were led by 2 paid staff, with support from 2 unpaid staff members, in mobilizing 28 community members from across 12 sectors to engage in the work of the coalition. Collectively, over 21,600 community members were mobilized in the 6 months preceding the current reporting submission (August 2016). School and youth sectors provided the highest median number of coalition members at 4 followed by law enforcement and parent sectors providing three members on average each. Schools and law enforcement were the two highest rated sectors on involvement (mean of 4.2). In addition, data collected for the first time in 2016 suggest that approximately two-thirds (65.9%) of coalitions have established a youth coalition where youth have the opportunity to lead on planning and engaging in activities with support from the broader coalition. Those coalitions with a youth coalition reported significantly higher involvement of the youth sector than coalitions without a youth coalition (4.2 and 3.2, respectively).

Activities engaged in by the DFC coalitions fall under each of the seven strategies, with at least 60% of DFC coalitions having used each of the strategies. Not surprisingly, a large number of activities are specifically engaged in with youth or are intended to have direct impacts on youth. These include trainings, alternative social events and recreation programs. In addition, 69% of DFC coalitions engaged in activities to reduce home and social access to substances (such as prescription drug take back programs). Finally, the most common policies/laws that DFC coalitions reported working to educate and inform the community about were associated with school policies. Collectively, these have resulted in high engagement of youth and may have contributed to an increase in youth in DFC communities who do not report engaging in substance use within the past 30-days.

An examination of DFC coalitions'; engagement on addressing opioids provides further evidence that DFC is succeeding at mobilizing communities and building capacity to address new issues as they arise in the community (see also Appendices B and C). Almost all DFC coalitions (88%) were targeting efforts to some extent to address opioids. Much of this work was related to education around prescription drugs and providing prescription drug take-back events, which 67% of DFC coalitions implemented as a result of receiving

DFC funding. DFC coalitions are also implementing or are active in task forces/subcommittees that focus on addressing opioids.

Limitations

In examining the core outcomes findings, it is worth noting that while DFC coalitions' grant activities were designed and implemented to cause a reduction in youth substance use it is not possible to establish a causal relationship as there is not an appropriate comparison or control group of communities from which the same data are available. In addition, this report includes analyses on core measures data provided for core measures that were introduced in 2012. Some core measures were unchanged in 2012 and data from 2002-2016 from a large number of DFC coalitions are available. The number of coalitions with change data on new core measures introduced in 2012 was typically much smaller (in some cases under 300 DFC coalitions have change data for new measures). This was especially true for the core measures on illicit use of prescription drugs. As additional data becomes available, it will become clearer if the findings to data are representative of the broad range of DFC coalitions.

In addition, each DFC coalition makes local decisions regarding how to collect core measure data. While most report collecting data in schools, this is not always the case. Few, if any, DFC coalitions collect data from youth not attending schools as these samples are harder to locate and may be less willing to complete surveys. Each DFC coalition's survey also varies in length and content. However, all surveys are reviewed by the DFC national evaluation team for the core measures and core measure data may only be entered if the item has been approved on the survey. Finally, DFC coalitions are encouraged to collect representative data from their capture area but each coalition is ultimately responsible for their own sampling strategies. DFC coalitions indicate any concerns about representativeness of samples when reporting the data.

Appendix A. Core Measure Items

Following is the recommended wording for each of the core measure items, in place since 2012. DFC coalitions submit surveys for review to ensure that they are collecting each given core measure item. For example, many DFC coalitions collect past 30-day prevalence of use by asking the number of days (0 to 30) in the past 30-days that the youth used the given substance. Any use is counted as "yes" and therefore the data are to be submitted.

TABLE A.1: Core Measure Items Recommended Wording (2012 to present)

Past 30-Day Prevalence of Use	Yes	No
During the past 30 days did you drink one or more drinks of an alcoholic beverage?	❑	❑
During the past 30 days did you smoke part or all of a cigarette?	❑	❑
During the past 30 days have you used marijuana or hashish?	❑	❑
During the past 30 days have you used prescription drugs *not prescribed to you*?	❑	❑

Perception of Risk	No Risk	Slight Risk	Moderate Risk	Great Risk
How much do you think people risk harming themselves physically or in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?	❑	❑	❑	❑
How much do you think people risk harming themselves physically or in other ways if they smoke one or more packs of cigarettes per day?	❑	❑	❑	❑
How much do you think people risk harming themselves physically or in other ways if they smoke marijuana once or twice a week?	❑	❑	❑	❑
How much do you think people risk harming themselves physically or in other ways if they use prescription drugs that are not prescribed to them?	❑	❑	❑	❑

Perception of Parental Disapproval	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your parents feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?	❑	❑	❑	❑
How wrong do your parents feel it would be for you to smoke tobacco?	❑	❑	❑	❑
How wrong do your parents feel it would be for you to smoke marijuana?	❑	❑	❑	❑
How wrong do your parents feel it would be for you to use prescription drugs not prescribed to you?	❑	❑	❑	❑

Perception of Peer Disapproval				
	Not at all wrong	A little bit wrong	Wrong	Very wrong
How wrong do your friends feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?	❑	❑	❑	❑
How wrong do your friends feel it would be for you to smoke tobacco?	❑	❑	❑	❑
How wrong do your friends feel it would be for you to smoke marijuana?	❑	❑	❑	❑
How wrong do your friends feel it would be for you to use prescription drugs not prescribed to you?	❑	❑	❑	❑

DFC coalitions are also permitted to collect and submit perception of risk and peer disapproval alcohol core measures associated with the Sober Truth on Preventing Underage Drinking Act (STOP) Act grant. These may be collected instead of or in addition to the respective DFC core measure. These data were not included in the current report. For perception of risk of alcohol use, the alternative item is "How much do you think people risk harming themselves (physically or in other ways) if they take one or two drinks of an alcoholic beverage nearly every day?" For peer disapproval, the item is worded as attitude towards peer use, "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?"

Appendix B. DFC Coalitions Lead the Way in Addressing the Opioid Epidemic

The Center for Disease Control (CDC) has identified opioid use and opioid overdose deaths as an epidemic, with deaths involving opioids (including prescription opioids and heroin) quadrupling from 2000 to 2015 to an average of 91 people dying of opioid overdose each day in America in 2015.[36] A primary goal of the DFC program is to build community capacity to address substance use. This is achieved by quickly identifying emerging community substance use issues and putting into place action plans to prevent the negative impacts. Data submitted by DFC coalitions as of August 2016 and preliminary analysis of data collected during site visits indicate DFC coalitions have built capacity to address opioids in their communities.

DFC Potential Reach and Focus on Opioids

One-fifth of the US population lives in an area with a DFC coalition and the majority of DFC coalitions are targeting at least one type of opioid in their coalition activities.

In 2016, nearly 1-in-5 Americans (19.7%) lived in a zip code served by a fiscal year (FY) 2015 DFC coalition. This included approximately 2.5 million middle school and 3.5 million high school youth.[37] At least one coalition in each of 38 states/territories (73% of the 52 states/territories with a DFC in FY 2015) mentioned in an open-ended response that they were working to address in their community.[38] In Ohio, a state in the CDC list of top 5 states with highest opioid overdose deaths in 2015, 79% of DFC coalitions mentioned addressing opioids in their August 2016 progress report.[39] At least half of the DFC coalitions in eight additional states mentioned opioids (see Appendix C).

Another indicator that DFC coalitions are focused on addressing opioids can be found in their selection of up to five substances the coalition is focused on addressing. In August 2016, 87.5% of DFC coalitions indicated that either heroin/opioids or prescription drugs

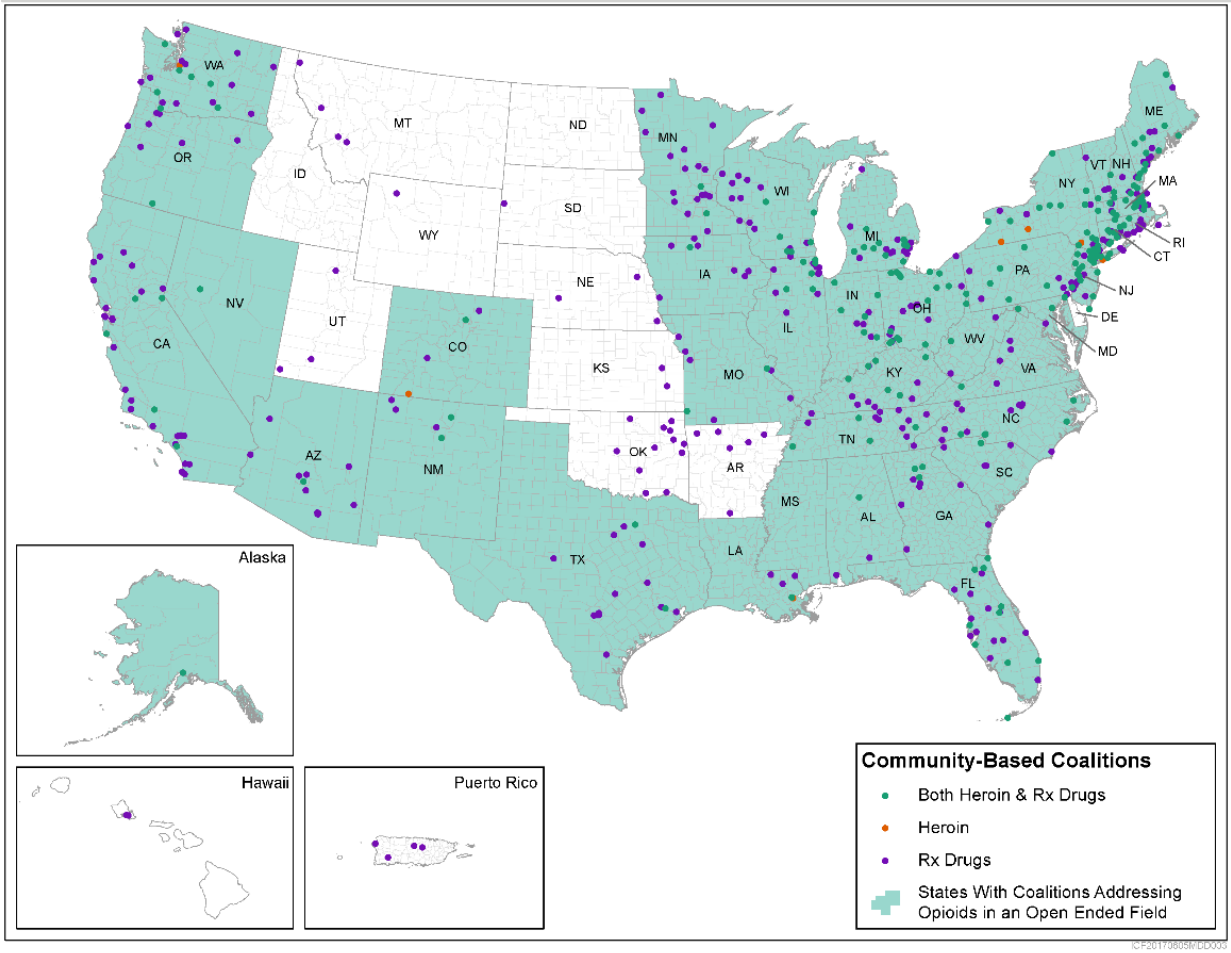
[36] CDC (2016). Drug overdose deaths in the United States Continue to increase in 2015. See https://www.cdc.gov/drugoverdose/epidemic/. For CDC data, please see: Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov

[37] See United States Census 2010 data Age and Sex Table by zip code tabulation area (ZCTA) retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP1&prodType=table DFC coalitions provide zip codes while the US Census uses ZCTAs. These are mostly the same (see https://www.census.gov/geo/reference/zctas.html). Note that some zip codes reported as served by DFC coalitions are not found in the Census ZCTA, typically because they represent smaller communities. That is, census estimates reported here are likely a conservative estimate of potential reach of the DFC grant.

[38] Additional DFC coalitions may have been working to address opioids but not included heroin or opioids as a term in their open text field responses in the August 2016 progress report.

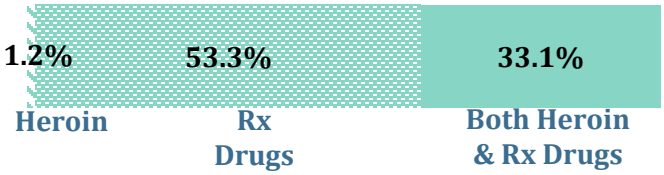
[39] CDC (2016). See footnote 36.

In **73%** of FY 2015 states/territories with a DFC coalition, **at least 1 DFC coalition mentioned opioids** (August 2016 Progress Report)



was a target focus for the coalition.[40] DFC coalitions understand the link between prescription drug use and opioid use: addressing prescription drugs is central to addressing opioids. A third (33%) of DFC coalitions (33%) indicated that both heroin and prescription drugs were the focus of coalition efforts.

88% of FY 2015 DFC coalitions targeted heroin, prescription (Rx) drugs, or both



[40] DFC coalitions targeting prescription drugs are not necessarily focused solely on prescription opioids, but prescription opioids are a central part of the focus. See also the map found in this appendix.

Finally, during site visits with DFC coalitions on addressing opioids, participants often noted that having a DFC coalition facilitated collaboration on the issue that would not otherwise have been possible. That is, they credited DFC with supporting collaboration in a way that contributed to the whole being greater than the sum of the parts to effectively address opioids.

Coalition Site Visit Voices: Building Capacity to Address Opioids

"We've been a coalition for over 10 years now and . . . ever since we got DFC funding it's really been about . . . a coordinated response to really bringing the 12 sectors together. I think that's something that prior to [the DFC coalition] hadn't been done. People worked in their silos on the issue, we had law enforcement working on enforcement. We had [local organization] doing prevention. The hospital working on their end but we never really had these sectors working together. So I think once [the DFC coalition] really got going that really began to happen." (Coalition 1)

"What's so great about the coalition, there's somebody to beat that drum. There is an organized cooperative collaborative partnering opportunity to facilitate conversations around drug use and how that affects our youth and how that affects our community. So DFC has been really an integral part of that. If that drum didn't exist I'm not so sure there would've been a mechanism in our community through which we all could've facilitated constructive and positive conversation . . . what this has done is it's allowed people a process through which to do that collaboratively and consistently. If everybody around this table had his or her own idea and we went off on our own direction and we did that well then we lack cohesiveness, we lack the ability to leverage resources from each other and I think that's what DFC has really done it has allowed us as a community to leverage resources in a way that's consistent and productive." (Coalition 2)

"What the coalition has been able to do was to raise visibility and awareness and start a conversation which are all things that attack stigma and the fear to ask for help, either from your minister or your physician or your school or police or whomever. The more visible we become as a group, that's going to increase." (Coalition 3)

The Path to Improved Community Outcomes

In August 2016 via open-text field responses in progress reports and during site visits, a small number of DFC coalitions noted successes with regard to addressing opioids. These include prevention work as suggested by reduced teen heroin use. A larger number of DFC coalitions commented on their successes around prescription drugs, including properly securing these substances and dropping off unused prescription medications during take-back events and at collection boxes. In

DFC coalitions have reported positive changes relating to their efforts in the community to address opioids

- Reducing overdose deaths and helping overdose survivors access treatment
- Reducing reported teen heroin use (survey data)
- Increasing awareness of securing and properly disposing prescription medications.
- Collecting thousands of pounds of medication through their collaborations with law enforcement and prescription drug take-back collection boxes

addition, DFC coalitions have noted success with reducing overdose deaths and helping families and people with substance use disorders access resources and treatment.

So how do DFC coalitions contribute to these successes? Broadly speaking, DFC coalitions typically begin with building coalition member and community awareness about the issue. As awareness increases, the DFC coalition begins to develop an action plan outlining key strategies. Here, preliminary examples of how DFC coalitions build community awareness and then some of their strategies including several promising practices are described.

While conceptually this is a logical progression, as the examples will show there is also often a synergy that occurs across steps that further contributes to improved community outcomes.

Building Coalition Member and Community Awareness

In order to address an issue, the DFC coalition often must first focus on defining what the issue is locally and then building awareness about the issue across both coalition members and relevant community members. In the case of opioids, in some cases the issue has been a significant community problem for a while and is impacting a broad range of generations in the community. In other communities, opioids are something the coalition is aware is growing as an issue but has currently had only minimal known impact locally. In August 2016, DFC coalitions mentioning opioids were generally mentioning it in the context of becoming a larger problem in their communities. Regardless, all DFC coalitions suggest awareness is key to developing next steps. Common strategies for building awareness include:

- Attend and/or plan informational summits, forums, and town halls with key stakeholders (e.g., local law enforcement, state and federal legislators, community members, health care providers, parents, youth)
- Develop education and media awareness campaigns, such as press conferences, radio ads, brochures, and billboards
- Target campaigns to be relevant to specific groups (e.g., parents and grandparents, realtors, senior centers, and funeral directors all were identified as targets for education on the importance of keeping prescription medications locked and inaccessible to youth)

DFC coalitions are engaging with new partners as well as traditional ones from the 12 sectors in order to address opioids, at times in ways that help coalition members to change their own approach.

As DFC coalitions build awareness in the community, new community members with an interest in addressing opioids often become engaged with the coalition. That is, new community members beyond those traditionally identified within the 12 sectors become engaged with the DFC coalition, further building capacity to address the issue. This often occurs because the DFC coalition has become the known group in the community to approach if you are having any issues around substance use. That is, increased awareness contributes to building capacity while increased capacity builds increased awareness.

One example has been the addition of a new groups from within school settings: athletic program staff, athletes, and their families. DFC coalitions noted the importance of engaging with athletic programs regarding risks associated with opioid use following an injury or surgery. An athletic director on one site visit noted, "I have 400 children that are out there participating and that's just one season. We have a large athletic department so we have a lot of athletes and I know a lot of the opioid issues time and time again have started from athletic injury so I feel that's the reason I got involved. I don't want to pretend there's no issue within our school and community, I want to try to get the right information out there for not only my own three kids but everybody else's kids so that's why I got involved."

Several coalitions also noted new engagement with maternal care providers, child protective services and child development agencies engaged in work with children impacted by family involvement in substance use. The need for such engagement became clear when a firefighter attending a DFC coalition task force meeting on prescription drugs asked for help in supporting children who witness overdoses or are exposed to opioid use. In one community, waste management started attending DFC meetings following concerns from waste management staff regarding their engagement with substances (e.g., needle cleanup, cleaning up methamphetamine labs, and cleaning up after parties in isolated community spaces). This has contributed to ongoing engagement between law enforcement and waste management in particular to identify hot spots for substance use issues in the community.

DFC coalitions work to address stigma and change attitudes about substance use in order to facilitate prevention activities.

Another key aspect to building awareness identified by DFC coalitions, particularly during site visits was the importance of addressing stigma and changing attitudes about substance use. One DFC coalition leader referenced the importance of scaffolding—understanding where coalition members and the community are at currently and working, sometimes slowly, from that point to shift perspectives through increased awareness. Coalition sector members shared the importance of the DFC role in overcoming stigma with us during site visits:

- "One of the things that the coalition and information I've gathered here has helped me most with is getting past the stigmas."
- "What the coalition has been able to do was to raise visibility and awareness and start a conversation which are all things that attack stigma and the fear to ask for help, either from your minister or your physician or your school or police or whomever. The more visible we become as a group, that's going to increase."

Two DFC coalitions noted specific successes in this area with regard to their work with law enforcement. In each case, members of law enforcement have become key advocates to helping others in the community understand that arresting users is not going to address the opioid epidemic.

Coalition Site Visit Voices: Shifting Law Enforcement Perspectives on Addressing Opioids

"Various centers of mental health and substance use policy have placed Florida in one of the states that has the highest amount of regulations and laws that incarcerate folks or arrest folks from various issues. . . . we had a member of the Sheriff's office get up before practitioners and tell you that it's a disorder, tell you it's a disease and tell you that we're not going to arrest our way out of that. . . .And he's been telling anybody that will listen. To have a member of the sheriff's office speak about a recovery orientation . . . it's such an outlier. And I think for them to come to the table and work in partnership with regulators and researches and educators to share in that philosophical approach is going to have tremendous implications for prevention" (Coalition 1, Project Coordinator)

"My entire career has been a drug cop, and when I got involved with [the DFC coalition] in 2011, it was a significant shift for me individually and for the department as a whole, we were trained to make arrests and do drug seizures and that's what we did. So when we got involved with [the DFC coalition] it was really a changing point in our law enforcement mission . . . it's expanded to this regional collaboration. We're a small community, we can't do it alone, so what we found early on through [the DFC coalition] was to reach out and hold people together. So we've expanded our reach with the surrounding towns and now we've gotten to a county-wide model." (Coalition 2, Law Enforcement Sector Member)

Taking Action to Address Opioids

While building capacity and awareness are ongoing efforts, DFC coalitions understand the importance of actually doing something as well. Developing and carrying out action plans early and often is central to how most DFC coalitions approach substance use prevention. A first action that several DFC coalitions reported engaging in was forming task forces or partnerships focusing on opioid prevention and education to bring together key

stakeholders, organizations and/or other communities facing the same challenges on an ongoing basis in order to both gather information and to strategize activities to address the issue. These coalitions set aside specific times to bring together key stakeholders to discuss how to address opioids in their communities.

One of the most consistent strategies to address opioids was to engage in a range of activities to address prescription drugs including:

- Working with the medical community to encourage responsible prescribing and monitoring practices, especially when prescribing to youth
- Sponsoring prescription drug take-back days and creating permanent drop box locations, with almost all DFC coalitions (94%) report having a prescription drug take-back event in their community and most (67%) of these programs were put into place as a result of their DFC grant award
- Educating athletes and their families, specifically, about risks associated with opioid use following an injury or surgery

67% of DFC coalitions reported the DFC grant enabled prescription drug take back in the community

DFC coalitions played a key role in addressing concerns around prescription drug disposal events as well as supporting and promoting them when they do occur. As one coalition leader noted during a site visit, "We've been working for two years trying to get a drug take back box there and we finally have that so now it's just a matter of getting more information out to the community of 'you can take your drugs there.' So I think we're pretty excited about that." Another site visit coalition had organized and sponsored nine local education workshops, "Opioid Overdose Prevention Series," educating over 400 healthcare and social services practitioners.

DFC coalitions also reported becoming engaged with hosting trainings for healthcare professionals, first responders, and community members on overdose reversal drugs (Narcan/Naloxone). These trainings were in some cases incorporated into trainings on understanding addiction more broadly in order to address the perceived need to overcome the stigma against those with substance use disorders held by some in the community.

Finally, DFC coalitions while focused primarily on prevention noted the need to engage in an integrated strategy approach with regard to addressing opioids. Specifically, they noted the need to understand treatment options in the community and connecting individuals with substance use issues and their families to appropriate resources and treatments. During site visits, a few of the coalitions noted that a real challenge to addressing opioids was the lack of available treatment programs locally or that local treatment programs were insufficient in size to meet the needs of the community in a timely manner. While these and other challenges exist (e.g., lack of resources and lack of prescription drug monitoring programs), one DFC coalition was engaged in several activities that might be considered

promising practices for other DFC coalitions to utilize in addressing opioids if the solution is appropriate locally.

Brockton Area Opioid Abuse Prevention Collaborative (Brockton, Massachusetts) has engaged in several promising practices to address opioids including a home visit program, drop-in resource centers, and enhanced school policy around trauma informed care.

The Brockton Area Opioid Abuse Prevention Collaborative is a regional coalition that was initially formed to specifically address opioid issues, but has evolved over the course of the past nine years to address underage drinking and other prescription drugs as well. Due to DFC funding, the Collaborative is able to leverage several other funding streams for their initiatives. The Collaborative was in year 8 of DFC grant funding when the site visit occurred in 2017.[41] During the site visit, several practices were highlighted by the coalition, often possible only because of the engagement of multiple sectors in the activity facilitated by the DFC coalition. These activities may provide a model that other communities could engage in if deemed appropriate to their local context.

- **Home Visits:** In this program, following an overdose incident if it is determined that in-person follow up may help, a plain clothes officer (safety official) and healthcare worker (e.g., substance abuse counselor, recovery coach, social worker) go to the home of the person and talk with them about what happened and about getting help. Visits occur within 24 hours of release from the hospital. If the person with substance use issues expresses interest in treatment, the team works to get the person into treatment as soon as possible. An independent study found that 85% of those who were approached accepted treatment, an early indicator of success.[42] This program was initiated by staff in law enforcement as they learned more about substance use from the DFC coalition and required collaboration with hospitals, healthcare providers and treatment centers. It is rooted in the understanding that some people with substance use disorders are afraid or embarrassed to ask for help. The initiative is county wide. In addition, this DFC coalition has already begun to share information about the program with others working to address opioids in the state. During another site visit in Massachusetts, this work was introduced during a regional task force meeting that was attended by three DFC coalitions in that region.

- **Drop-in Centers:** The coalition introduced a "one-stop shop", drop-in center available to community members at least once each month. The drop-in center is located at a local church. At-risk users and family members can receive Narcan training (and Narcan) from the center. Over 30 agencies and organizations have partnered with the drop-in center to

[41] The DFC National Evaluation team thanks all eleven coalitions visited to date to better understand how coalitions are addressing opioids. While we have highlighted one here, all eleven provided the evaluation with considerable time and information highlighted throughout this brief. A more extensive brief on lessons learned from site visits is forthcoming. Site visit findings reported here are preliminary.

[42] Mashberg, T. (2016). Combating opioid addiction in Massachusetts: A hospital-based solution shows promise in reducing relapses and ER costs. Pioneer Institute for Public Policy Research. See http://pioneerinstitute.org/healthcare/study-bid-plymouth-program-shows-promise-battling-opioid-abuse/

offer information on available mental health services, referral and access to inpatient and outpatient services, and family education and support. When possible and appropriate, volunteers introduce attendees to treatment plans and help with placement.

- **Opioid Alerts:** To build awareness of the extent of opioid overdoses in the community, a coalition member in the medical field started sending out overdose alerts in 2014. Frontline workers, in Brockton and the neighboring communities receive daily alerts of overdose victims. As appropriate, this is also another opportunity to reach out and connect with the individual to provide appropriate wrap around services and see if they can get them into treatment.
- **Enhanced School Policy around Trauma Informed Care**: The DFC coalition has introduced a Handle with Care program.[43] The police provide the school with an alert when a child witnesses something traumatic like an overdose. The alert lets the school know that the child experienced something that may impact their behavior and/or performance in school in case the school can provide support. The alert is not specific to the incident but an alert that the child may need to be handled with care. Teachers at the school receive training from the DFC coalition on how they might work with children who have experienced an event.

Summary

DFC coalitions are leading the way on addressing opioids in communities across the United States. They are engaged in a broad array of practices that range from community mobilization and awareness to community action that ultimately result in community outcomes. As they work to address opioids, DFC coalitions are engaging with ongoing and new, relevant community sector members as appropriate. Central to work on addressing opioids is raising awareness and addressing stigmas associated with substance use. DFC coalitions have also targeted significant effort on a range of activities to educate community members about prescription drugs and to introduce prescription drug take-back programs into the community, often as a direct result of receiving DFC funds. While no one strategy is likely to fully address opioids across communities, several promising practices from a DFC coalition in Massachusetts provide further evidence of the central role that DFC coalitions can play. These practices are innovative and result from the cross-sector collaboration that is at the core of the DFC program.

[43] Handle with Care originated in West Virginia. See (http://www.handlewithcarewv.org/handle-with-care.phphttp://www.handlewithcarewv.org/handle-with-care.php).

Appendix C. Opioid State Counts

TableC.1. DFC Coalitions August 2016 Progress Report Data (FY 2015 coalitions) on Opioids Relative to Center for Disease Control data from 2015

Center for Disease Control Notes[a]	State	# of DFC Coalitions in State Who Mentioned Opioids in Open Text Field	# of DFC Coalitions in State Submitting August 2016 report (# of DFC Coalitions in State, if Different)	% of DFC Coalitions in State Submitting August 2016 Report Who Mentioned Opioids in Open Text Field
A,B,C	OH	19	24 (25)	79.2%
B,C	CT	13	21	61.9%
A,B,C	RI	4	7	57.1%
B,C	ME	10	18 (19)	55.6%
C	NC	8	15	53.3%
C	NY	24	47 (48)	51.1%
	AK	1	2	50.0%
	CO	3	6	50.0%
	MS	1	2	50.0%
B,C	MA	15	31	48.4%
	IN	6	14	42.9%
C	NJ	10	24 (25)	41.7%
A,B,C	NH	4	10	40.0%
	WI	7	21	33.30%
C	MI	8	25	32.0%
A,B,C	KY	6	20 (21)	30.0%
C	FL	8	28	28.6%
C	MD	2	7	28.6%
B	NM	2	7	28.6%
B,C	PA	5	19	26.3%
	SC	3	12	25.0%
	VT	1	4	25.0%
A,B,C	WV	2	8	25.0%
	MO	2	9	22.2%
	GA	3	14	21.4%
	AL	1	5	20.0%
	TX	3	15 (17)	20.0%
	CA	7	41 (46)	17.1%
	OR	2	12	16.7%
C	IL	4	25	16.0%

[a]CDC Notes:

A= **State in CDC Top 5 opioid overdose deaths in 2015 (dark salmon box)**

B=**State in CDC highest category of opioid overdose deaths in 2015, (age adjusted rates of 21-41.5); Note that all states in the Top 5 are also in the highest category (light salmon box)**

C=**Statistically Significant Increase in Opioid Deaths from 2014 to 2015 (gold box)**

Appendix C. Table C.1 (continued)

Center for Disease Control Notes[a]	State	# of DFC Coalitions in State Who Mentioned Opioids in Open Text Field	# of DFC Coalitions in State Submitting August 2016 report (# of DFC Coalitions in State, if Different)	% of DFC Coalitions in State Submitting August 2016 Report Who Mentioned Opioids in Open Text Field
	OK	2	13	15.4%
B,C	TN	2	14 (15)	14.3%
	VA	1	7	14.3%
	MN	3	27	11.1%
	IA	1	11	9.1%
	AZ	1	15 (17)	6.7%
C	WA	1	26 (28)	3.8%
	AR	0	6 (7)	0.0%
	AS	0	1	0.0%
	DC	0	4	0.0%
	DE	0	1	0.0%
	FM	0	0 (1)	0.0%
	HI	0	2	0.0%
	KS	0	3	0.0%
C	LA	0	8	0.0%
	MT	0	5 (6)	0.0%
	NE	0	5	0.0%
	NV	0	1	0.0%
	PR	0	5	0.0%
	SD	0	3	0.0%
B	UT	0	3	0.0%
	WY	0	2	0.0%
	All States	**195**	**655 (675)**	**29.8%**

Sources: August 2016 DFC Progress Report, CDC data
https://www.cdc.gov/drugoverdose/data/statedeaths.htmlhttps://www.cdc.gov/drugoverdose/data/statedeaths.html

[a]CDC Notes:

A= **State in CDC Top 5 opioid overdose deaths in 2015 (dark salmon box)**

B=**State in CDC highest category of opioid overdose deaths in 2015, (age adjusted rates of 21-41.5); Note that all states in the Top 5 are also in the highest category (light salmon box)**

C=**Statistically Significant Increase in Opioid Deaths from 2014 to 2015 (gold box)**

Appendix D. Core Measures Data Tables

TABLE D.1: LONG-TERM CHANGE IN PAST 30-DAY PREVALENCE OF USE[a]

School Level Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2014 DFC Grant Award Recipients n	% Report Use, First Outcome	% Report Use, Most Recent Outcome	% Point Change
Middle School								
Alcohol	1120	12.6	9.2	-3.4*	491	11.5	7.2	-4.3*
Tobacco	1114	6.3	4.3	-2.0*	484	5.5	3.0	-2.5*
Marijuana	1103	5.0	4.3	-0.7*	484	4.7	3.9	-0.8*
Prescription Drugs	311	2.8	2.5	-0.3*	274	2.9	2.5	-0.4*
High School								
Alcohol	1189	36.1	29.3	-6.8*	530	34.7	26.0	-8.7*
Tobacco	1172	18.1	13.0	-5.0*	516	16.6	10.2	-6.4*
Marijuana	1172	18.2	17.1	-1.2*	519	18.2	17.1	-1.2*
Prescription Drugs	353	6.3	5.3	-1.0*	313	6.5	5.3	-1.2*

Notes: * p<.05; n represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding

[a] Outcomes represent weighted averages for each DFC grantee based on the total number of youth used in the percentage point change calculation (i.e., adding number of youth surveyed at first observation to number surveyed at most recent observation). Outliers beyond 3 standard deviations were removed. All numbers were rounded.

Source: Progress Report, 2002-2016 core measures data

TableD.2 provides the same data as in Table D.1, but calculated as prevalence of non-use of substances in the prior 30-days. These are calculated as 100% minus prevalence of past-30-day use.

TABLE D.2: LONG-TERM CHANGE IN PAST 30-DAY PREVALENCE OF NON-USE[a]

School Level Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report Non-Use, First Outcome	% Report Non-Use, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2014 DFC Grant Award Recipients n	% Report Non-Use, First Outcome	% Report Non-Use, Most Recent Outcome	% Point Change
Middle School								
Alcohol	1120	87.4	90.8	3.4*	491	88.5	92.8	4.3*
Tobacco	1114	93.7	95.7	2.0*	484	94.5	97.0	2.5*
Marijuana	1103	95.0	95.7	0.7*	484	95.3	96.1	0.8*
Prescription Drugs	311	97.2	97.5	0.3*	274	97.1	97.5	0.4*
High School								
Alcohol	1189	63.9	70.7	6.8*	530	65.3	74.0	8.7*
Tobacco	1172	81.9	87.0	5.0*	516	83.4	89.8	6.4*
Marijuana	1172	81.8	82.9	1.2*	519	81.8	82.9	1.2*
Prescription Drugs	353	93.7	94.7	1.0*	313	93.5	94.7	1.2*

Notes: * p<.05; n represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding

[a] Outcomes represent weighted averages for each DFC grantee based on the total number of youth used in the percentage point change calculation (i.e., adding number of youth surveyed at first observation to number surveyed at most recent observation). Outliers beyond 3 standard deviations were removed. All numbers were rounded.

Source: Progress Report, 2002-2016 core measures data

TABLE D.3: LONG-TERM CHANGE IN PERCEPTION OF RISK/HARM OF USE[a]

School Level Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2014 DFC Grant Award Recipients n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
Middle School								
Alcohol	331	69.4	73.2	3.8*	281	69.6	72.9	3.3*
Tobacco	1036	80.5	81.4	0.9*	450	80.2	80.3	0.0
Marijuana	298	72.5	71.6	-0.9	261	72.3	71.5	-0.8
Prescription Drugs	246	80.5	81.3	0.8	222	82.0	82.6	0.6
High School								
Alcohol	361	70.7	72.8	2.1*	308	70.7	72.5	1.8*
Tobacco	1086	80.8	82.8	2.0*	477	80.7	82.5	1.8*
Marijuana	323	55.7	53.1	-2.6*	285	55.3	52.8	-2.5*
Prescription Drugs	280	82.5	82.7	0.2	254	83.5	83.6	0.1

Notes: * p<.05; n represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding

[a] Outcomes represent weighted averages for each DFC grantee based on the total number of youth used in the percentage point change calculation (i.e., adding number of youth surveyed at first observation to number surveyed at most recent observation). Outliers beyond 3 standard deviations were removed. All numbers were rounded, percentage point chance was rounded after taking the difference score.

[b] perception of risk of five or more drinks once or twice a week

[c] perception of risk of smoking 1 or more packs of cigarettes per day

[d] perception of risk of smoking marijuana 1-2 times per week

[e] perception of risk of any use of prescription drugs not prescribed to you

Source: Progress Report, 2002-2016 core measures data

TABLE D.4: LONG-TERM CHANGE IN PERCEPTION OF PARENTAL DISAPPROVAL[a]

School Level Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2014 DFC Grant Award Recipients n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
Middle School								
Alcohol	251	93.8	94.3	0.4	226	93.6	94.1	0.5
Tobacco	982	91.2	93.8	2.6*	436	93.3	94.8	1.5*
Marijuana	1001	92.4	94.1	1.7*	440	94.0	94.6	0.6
Prescription Drugs	241	95.4	95.2	-0.2	219	95.4	95.1	-0.3
High School								
Alcohol	277	87.1	89.6	2.6*	249	87.1	89.7	2.6*
Tobacco	1038	84.8	88.0	3.3*	464	86.6	90.2	3.5*
Marijuana	1045	86.1	86.7	0.7*	467	86.1	85.6	-0.5
Prescription Drugs	274	93.2	93.6	0.5	249	93.1	93.6	0.5

Notes: * p<.05; n represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding

[a] Outcomes represent weighted averages for each DFC grantee based on the total number of youth used in the percentage point change calculation (i.e., adding number of youth surveyed at first observation to number surveyed at most recent observation). Outliers beyond 3 standard deviations were removed. All numbers were rounded.

[b] perception of disapproval of one or two drinks of an alcoholic beverage nearly every day

[c] perception of disapproval of any smoking of tobacco or marijuana

[d] perception of disapproval of any use of prescription drugs not prescribed to you

Source: Progress Report, 2002-2016 core measures data

TABLE D.5: LONG-TERM CHANGE IN PERCEPTION OF PEER DISAPPROVAL[a]

School Level Substance	Long-Term Change: First Observation to Most Recent All DFC Grant Award Recipients Since Program Inception n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change	Long-Term Change: First Observation to Most Recent FY 2014 DFC Grant Award Recipients n	% Report, First Outcome	% Report, Most Recent Outcome	% Point Change
Middle School								
Alcohol	229	84.9	87.1	2.2*	207	84.8	86.7	1.8*
Tobacco	244	86.8	88.5	1.6*	218	87.3	88.4	1.1*
Marijuana	253	85.6	86.6	1.0*	225	85.9	86.5	0.6
Prescription Drugs	225	89.9	90.7	0.8*	205	89.7	90.4	0.7
High School								
Alcohol	265	62.7	68.4	5.7*	239	62.1	68.0	5.8*
Tobacco	270	66.9	73.0	6.1*	242	66.5	72.8	6.3*
Marijuana	278	55.3	57.2	1.9*	248	55.2	57.0	1.8*
Prescription Drugs	252	79.2	82.0	2.8*	230	78.6	82.0	3.5*

Notes: * p<.05; n represents the number of DFC coalitions included in the analysis; difference scores may not equal percentage point change due to rounding

[a] Outcomes represent weighted averages for each DFC grantee based on the total number of youth used in the percentage point change calculation (i.e., adding number of youth surveyed at first observation to number surveyed at most recent observation). Outliers beyond 3 standard deviations were removed. All numbers were rounded.

[b] perception of disapproval of one or two drinks of an alcoholic beverage nearly every day

[c] perception of disapproval of any smoking of tobacco or marijuana

[d] perception of disapproval of any use of prescription drugs not prescribed to you

Source: Progress Report, 2002-2016 core measures data